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KANSAS HEALTH POLICY AUTHORITY

2009 Medicaid Transformation Program Review
HealthWave Program

KHPA does not typically evaluate its programs every year. The pace of change in each program is usually longer than a year, and the number of programs inhibits annual evaluation by our staff. However, the HealthWave program represents the single largest line item expenditure among the Medicaid programs directly managed by KHPA. In addition, the single recommendation in last year's evaluation suggested actions that could be taken quickly. As a result we have included HealthWave among the 2009 program reviews in order to provide updated data and to follow up on the 2008 recommendation to enhance quality improvement activities in the program. Additional reports have been received by KHPA which are not part of the evaluation time period for this review but will be utilized in future reviews. Reports may be accessed at http://www.khpa.ks.gov/quality_reports/healthwave.html.

Description

The HealthWave program was developed to provide comprehensive, quality health coverage for low income children and families across the state of Kansas. Medical care is offered through a combination of fee-for-service (FFS) coverage and direct contracts with two physical health managed care organizations (MCOs), Children's Mercy Family Health Partners (CMFHP) and UniCare Health Plan of Kansas (UniCare). The majority of Medicaid beneficiaries, including all HealthWave 19 (HW 19) members, receive mental health care from Kansas Health Solutions (KHS) through the Prepaid Ambulatory Health Plan (PAHP) and substance abuse care from Value Options (VO) through the Prepaid Inpatient Health Plan (PIHP). HealthWave 21 (HW 21) participants (those who receive care through the Children's Health Insurance Program – CHIP), receive mental health services through a capitated managed care contract with Cenpatico Behavioral Health (CBH).

HealthWave offers access to health care for two populations, HW 19 and HW 21, yet functions as a single program with no difference in the physical health coverage. Eligibility for HW 19 and HW 21 is based on age and household income. Because of the stairstep eligibility for each program (see Table 1, HealthWave Eligibility), approximately 20% of members are from "blended" families with children enrolled in both HW 19 and HW 21 concurrently. While HW 19 provides health care coverage to children and parents who fall below a certain income, HW 21 provides care to children only; who are age 0-18 and whose family incomes' are higher than HW 19 levels but below 200% of the federal poverty level. The primary differences in HW 19 and HW 21 are the populations served and the federal funding sources for each.

Table 1 - HealthWave Eligibility

<table>
<tr><th>Family Poverty Level</th><th>Newborns under age 1</th><th>Children ages 1-5</th><th>Children ages 6-18</th></tr>
<tr><td>176-200% FPL</td><td colspan="3">CHIP, $30 Monthly Premium Per Family</td></tr>
<tr><td>151-175% FPL</td><td colspan="3">CHIP, $20 Monthly Premium Per Family</td></tr>
<tr><td>≤150% FPL</td><td rowspan="3">Medicaid, No Premium</td><td colspan="2">CHIP, No Premium</td></tr>
<tr><td>≤133% FPL</td><td colspan="2">Medicaid, No Premium</td><td>CHIP, No Premium</td></tr>
<tr><td>≤100% FPL</td><td colspan="3">Medicaid, No Premium</td></tr>
</table>

CMFHP and UniCare, the physical health MCOs, are required to provide coverage equal to or greater than the Medicaid FFS program. While capitation rates, or fixed advance payments, to MCOs are based upon the presumed cost of unmanaged FFS payments/services less an acutuarial adjustment for the assumed savings in managed care, contracted health plans offer some additional services to their members, and use the administrative component of the capitation payments to invest in disease management and other mechanisms to manage care.

Health Plans Serving the HealthWave Population

HealthWave coverage for HW 19 and HW 21 members includes the medical services and benefits provided by UniCare and CMFHP as well as dental, mental health, and substance abuse services offered through other mechanisms. The mental health coverage provided by CBH is equivalent to the State Employee Health Plan with the addition two traditional Medicaid community based services: Community Psychiatric Supportive Treatment and Psychosocial Rehabilitation Group Therapy. In 2008, Intensive Care Management was also added as a benefit for HW 21 members with complex mental health needs. Dental benefits for both HW 19 and HW 21 members are reimbursed through the FFS model and provide most dental services; however, orthodontia is limited to children with genetic abnormalities or severe trauma. Dental coverage for adults is limited to emergent care and is also covered as a FFS benefit. Table 2 provides a condensed version of coverage responsibilities.

Table 2 - Programs and Benefits for HealthWave Families

Type of Service	Health Plan	Benefits Coverage	Method of Payment	Population Served
Physical Health Services (Medical)	Children's Mercy Family Health Partners	HealthWave (HW) equivalent to Medicaid FFS plus value added services	Risk Based Capitation	HW 19 / HW 21 Children HW 19 Adults
	UniCare Health Plan of Kansas	HW equivalent to Medicaid FFS plus value added services	Risk Based Capitation	HW 19/HW 21 Children HW 19 Adults
Dental	Kansas Medicaid Program (EDS)	HW 19 / HW 21 children receive identical comprehensive coverage. HW 19 adults receive emergency care.	FFS	HW 19/HW 21 Children HW 19 Adults
Mental Health Services	Cenpatico Behavioral Health	Equivalent to the State Employee Health Plan plus value added services	Risk Based Capitation	HW 21
	Kansas Health Solutions	SRS-contracted list of covered services	Cost-Based Capitation	most Title 19, plus MediKan, excluding NF
Substance Abuse Services	Cenpatico Behavioral Health	Equivalent to the State Employee Health Plan	Risk Based Capitation	HW 21
	Value Options	SRS-contracted list of covered services	Risk Based Capitation	Title 19 excluding NF and MediKan

Managed Care Enrollment in Kansas Medicaid and CHIP

In 2008, unduplicated enrollment for both HW 19 and HW 21 was 161,498. This represents about 54% of the Kansas Medical Assistance Programs population, compared to 139,025, or 51.1%, in 2007. This percentage is below regional and national averages for Medicaid managed care enrollment. According to a report released by CMS in January 2009 (2007 Medicaid Managed Care Enrollment Report, Summary Statistics as of June 30, 2007), Region VII – which includes Kansas, Iowa, Missouri, and Nebraska – had a FY 2007 managed care enrollment rate of 56.13%, compared to the national average of 64.10%. Region VII accounted for the lowest managed care enrollment percentage in the country.

National trends from 1998 through 2006 showed an increase in the number and percentage of beneficiaries who received their coverage through managed care, with a slight dip in percentage for 2007. Although trailing regional and national averages, Kansas HealthWave enrollments are trending higher, as well. One reason for the difference could be related to the population states choose to enroll in managed care. HealthWave provides care only for pregnant women, children, and some low income parents.

As the population of the country ages, and as chronic diseases have become more widespread and associated costs for care have escalated, many states have responded by looking at some form of care management or "managed care" as a possible solution for their most expensive populations. Nationally, at least 16 states offer some level of enhanced care for their dual eligible beneficiaries (those who participate in both Medicaid and Medicare), ranging from disease specific care management to full Medicaid managed care.

Kansas implemented a pilot project (Enhanced Care Management) in one metropolitan area of the state in 2006 to determine the effectiveness of care management for members with complex needs who are not enrolled in managed care. Chapter 13 – Medical Services for the Aged and Disabled – of KHPA's 2008 Medicaid Transformation report describes the ECM project in detail and relays KHPA's plans to develop an application of the medical home to help address the physical health needs of Medicaid's high cost populations. KHPA is currently developing an implementation plan for a medical home project for high cost/high needs Medicaid beneficiaries with a technical assistance grant through the National Academy for State Health Policy's Consortium to Advance Medical Home. However, implementing the medical home model will require reimbursement reform and an increase in expediture that cannot be supported in the current fiscal climate. In addition to the development of a medical home, and the advances in care management that a medical home brings, KHPA may also need to consider other approaches to address rising needs of its high-cost populations, including contracting for various care management services, investing in tele-monitoring services, or pursuing the kind of prepaid, outsourced management available through programs like HealthWave. Another Medicaid Transformation 2008 initiative is to work through Medicaid home health service workers to enhance beneficiaries' ability to manage the debilitating and costly complications of diabetes (see Chapter 5).

Health Care Management Efforts in the Physical Health MCO's

Health care management services offered by both MCOs include but are not limited to pregnancy care management and disease-specific health management programs such as asthma, diabetes, obesity, and cardiovascular disease, and prevention efforts. Chronic disease and pregnancy care managers contact beneficiaries with special needs and offer help in coordinating doctors' appointments, securing specialist care when appropriate, and accessing community-based services. Table 3 reflects the unique number of beneficiaries with chronic illness, high risk pregnancy, or both, who chose to participate in care management in UniCare or CMFHP during the first two calendar years of their contract with the state. During this time, 8,341 HW 19 and 1,211 HW 21 received some type of management. The average percentage of the quarterly average HW 19 members receiving care management services during CY 07 and 08 was approximately .86% while .40% of the HW 21 population were served. More recent data indicates an increase in the percentage of HealthWave members participating in care management activities.

Table 3 - Care Management

	% of HW Population Receiving Care Management by Quarter								
	Q1 07	Q2 07	Q3 07	Q4 07	Q1 08	Q2 08	Q3 08	Q4 08	Qrtly Avg
HealthWave 19	.27%	.53%	.77%	.74%	.88%	1.07%	1.20%	1.44%	.86%
HealthWave 21	.06%	.16%	.22%	.26%	.43%	.79%	.62%	.65%	.40%

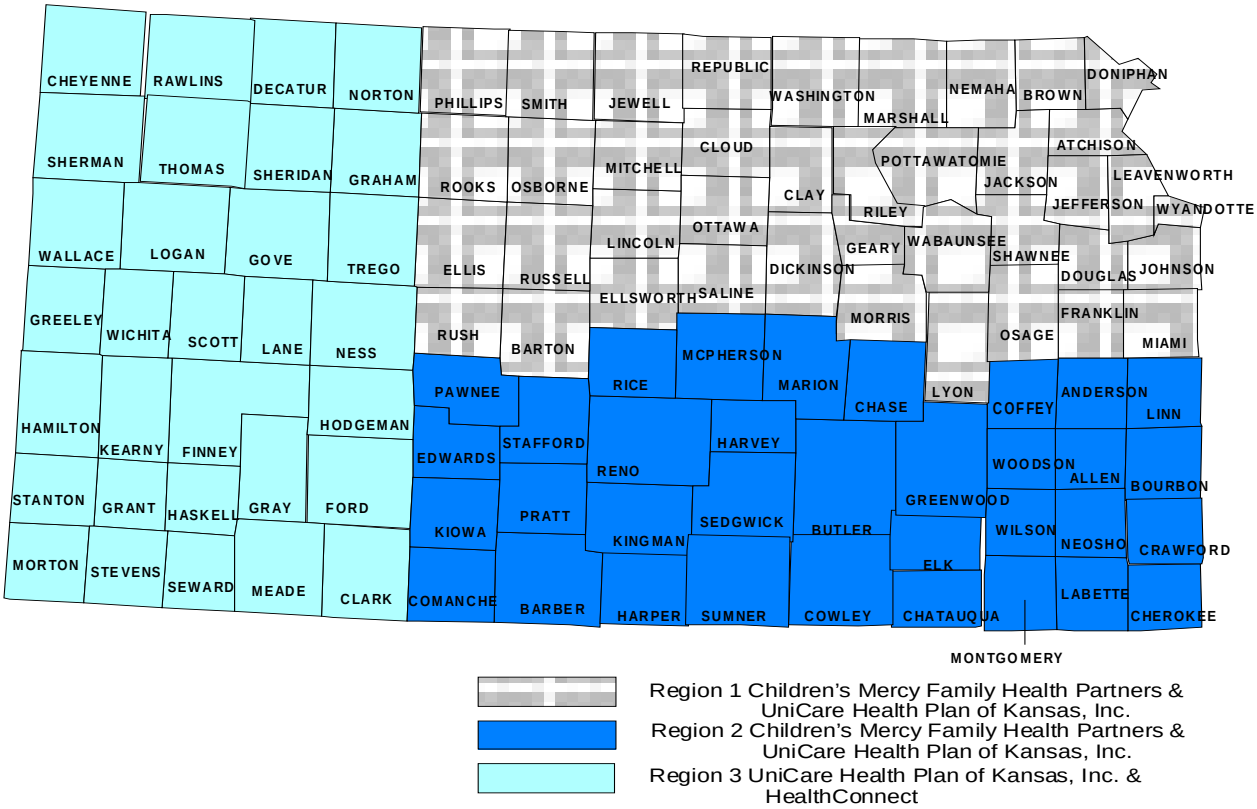
Care management, where professional staff assist beneficiaries who may need additional support, is intended to both reduce costs and improve beneficiary health. Health plans competitively bid for the fixed payment they will receive from KHPA for each HealthWave member each month, and this bid is based in part on their assessment of the amount of savings they can achieve through care management and other techniques, as compared to the costs of an unmanaged population. Care management is not limited to members afflicted with chronic illnesses and conditions who have been targeted by the plans for interventions. Identification of appropriate members is accomplished through the use of claims information which includes but is not limited to diagnoses, service type accessed, pharmacy utilization information and cost. Health coaches work with members who elect to overcome some of the barriers they face to optimal health. Health coaches may educate and support members who tend to use the emergency room in place of a primary care provider (PCP), have unusual needs, or have been recently discharged from the hospital. Many times, care managers and health coaches support members whose needs extend beyond medical concerns and include complex social and or economic concerns. MCO care management staff maintain regular contact with high need members, sometimes through phone calls but also through face to face contact when the need is justified. The level of support is based upon each member's individual needs, and may vary from one month to the next. Successful health coaching can be defined by cases in which the members are better equipped to navigate the health care system to access the appropriate level of care when and where it is needed. Accurate data reflecting the number of unique members receiving the services of health coaching is to be provided by the plans during 2009 and explored during the 2009 program review.

Population Distribution

HealthWave Service Regions

The state is divided into three distinct service regions which serve HealthWave beneficiaries. Approximately 95% of all HealthWave beneficiaries reside in Regions 1 and 2. The service regions, as well as the managed care plans active in each region, are identified in Figure 1.

Figure 1 - HealthWave Service Regions



HealthWave experienced a significant transition in January 2007, when it moved from a one-MCO program to a competitive two-MCO program for physical health. Contracting with CMFHP and UniCare allowed HealthWave to expand managed care enrollment in Regions I and 2 to approximately 50,000 HW 19 members who were previously covered by the fee for service (FFS) Medicaid program through HealthConnect Kansas's (HCK) network of primary care case managers. UniCare's contract with the state covers all three regions; CMFHP's contract covers Regions 1 and 2. Therefore, HW 19 and HW 21 members in Regions 1 and 2 choose between CMFHP and UniCare. Federal regulations prohibit HealthWave from requiring HW 19 members to participate in managed care if they do not have a choice of health plans. HW 19 members in Region 3 choose between UniCare and HCK, which serves members through the FFS Medicaid program. HW 21 members in Region 3 are all assigned to UniCare, as allowed by federal guidelines.

Trends in HealthWave Enrollment: Medicaid (HW 19) v CHIP (HW 21)

HealthWave enrollment grew in 2008, the first fully operational year under the expanded two-MCO program. The growth also corresponds with the increase in staff and resources at the HealthWave Clearinghouse. The Kansas Legislature funded these additional resources in 2007

in order to administer new citizenship and identity documentation requirements that were implemented by by federal mandate in 2006.

Figure 2 shows the point-in-time Medicaid enrollment by program since 2005. The chart illustrates a dramatic decrease in HCK enrollment, and a corresponding increase in HW 19, when the HealthWave program expanded in 2007.

Figure 2 - Medicaid Enrollment by Program

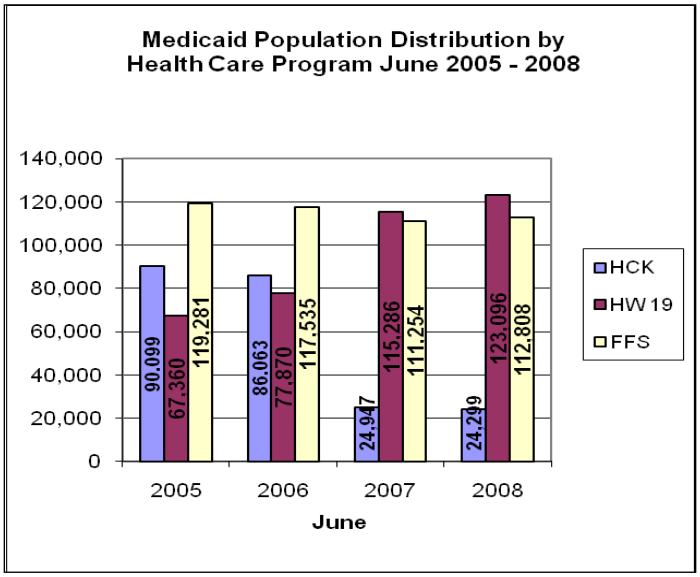


Figure 3 and Table 4 represent growth rates since the HW expansion, and reflect slight decreases in HCK and increases for HealthWave, including a nearly 9% increase in HW 21 enrollment, with CMFHP experiencing the greatest 2008 growth rate in HW 21 enrollment. UniCare's HW 19 population growth rate exceeded CMFHP's, and was fairly consistent with its HW 21 growth rate.

Both HW 19 and HW 21 experienced positive growth. However, HW 19 grew significantly faster from FY 2005 – 2007. This increase can be attributed to removing the limit on the number of Medicaid beneficiaries that the previous MCO served. There was also an increase in enrollment in HW 19 from FY 2006 – 2008. This change represents program growth due to the transition to multiple MCOs. The decline in membership of HW 21 in FY 2007, (shown in Figure 4) is related to the spillover effects of the backlog created by the federal citizenship documentation requirements. The approximately 20,000 person decline in FY 2007 HW 19 due to citizenship documentation is masked in Figure 5 by the larger increase in enrollment that year following the transition to multiple MCOs.

HealthWave Enrollment in each Physical Health MCO

With the onset of recession and significant increases in unemployment in late 2008, the eligibility clearinghouse received a significant increase in HealthWave applications. Though KHPA shifted resources to address the increased number of applications, a new backlog of approximately 14,000 unprocessed applications had emerged by the end of FY 2009.

Figure 3 - 2008 Population Distribution by Quarter

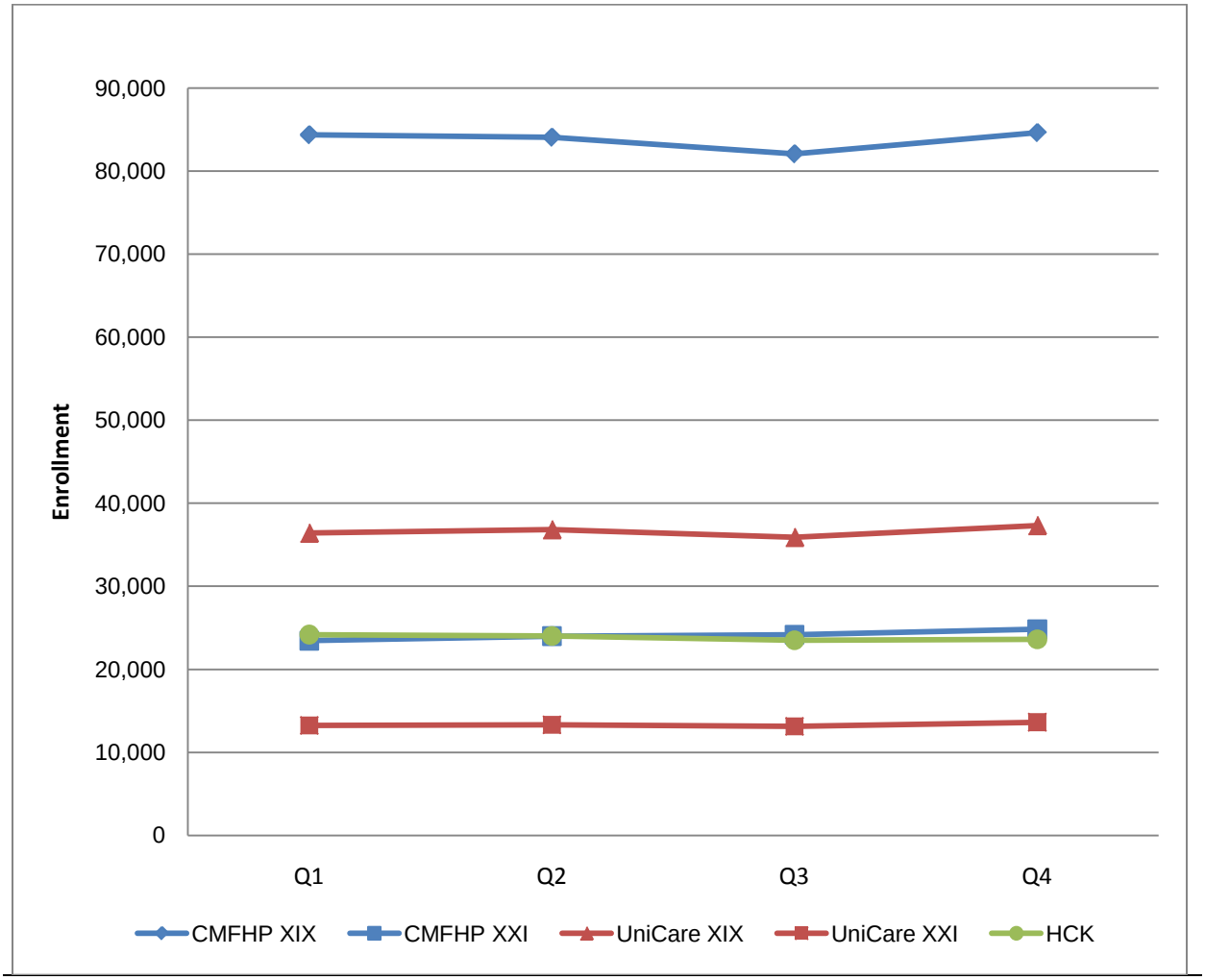


Table 4 - 2008 Population Growth

Growth Rate Q1 - Q4 CY2007 and 2008		
Managed Care Plan	Growth Rate CY2007	Growth Rate CY2008
CMFHP HW 19	14.95%	0.30%
CMFHP HW 21	11.99%	5.87%
UniCare HW 19	1.43%	2.52%
UniCare HW 21	5.89%	2.83%
HCK	-0.99%	-2.37%

Figure 4 - HW 19 Total Growth FY 2004 – 2008 Unduplicated Members

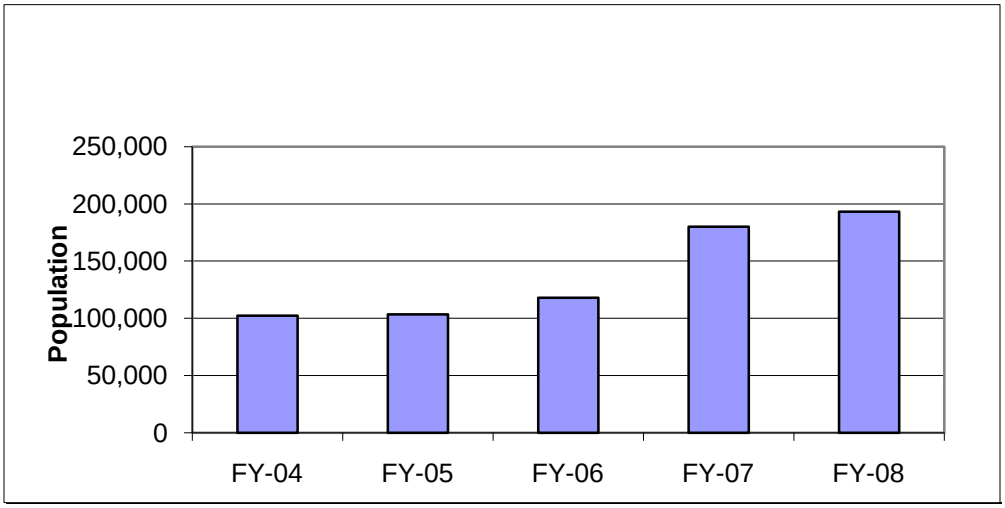
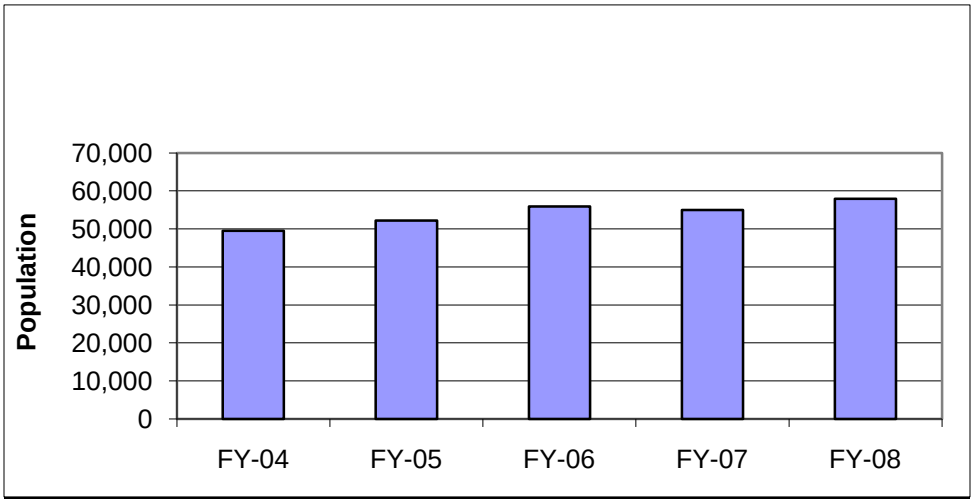


Figure 5 - HW 21 Total Growth FY 2004 – 2008 Unduplicated Members



Once enrolled, HW 19 participants are asked to choose an MCO, either CMFHP or UniCare. If an enrollee does not choose a plan, one is randomly selected for the participant by an "autoassign" process that is equitable to both health plans. In 2008, 43.29% of HW 19 members actively enrolled with a health plan. HW 21 beneficiaries are autoassigned to an MCO and may elect to switch if they reside in Regions 1 or 2.

One consistent challenge for HealthWave, the MCOs, providers, and participants is the current process for participants who have a break in eligibility. When eligibility is reestablished, managed care is suspended for a month, during which the participant care reverts to FFS. This causes "churning" where participants go from a managed care plan to FFS coverage, then back

to a managed care plan. As a result, providers note an interim change in coverage that is confusing and frustrating, and billing issues may arise. Ninety-eight percent of the time, mid-year changes in a beneficiary's MCO plan are due to the impact of short gaps in eligibility, i.e., churning; only two percent is due to participants choosing to switch from one managed care plan to the other.

A solution to switching between FFS coverage and health plans is to reduce temporary loss of eligibility. The temporary loss of HealthWave eligibility is due to various causes, and reducing or eliminating them will require sustained, long term, and coordinated efforts by all stakeholders. On average, 70% of HealthWave consumers return their review at the end of their eligibility period. Many families whose coverages lapse reapply when their children are again in need of medical services. In an effort to reduce churning, a post card is mailed two weeks prior to the annual eligibility review to prepare the family for the upcoming review process. The review application is then mailed to the family 45 days prior to the end of coverage to allow ample time for submission and processing. Although the review application process is similar to the initial application for HealthWave coverage, many families fail to submit required documentation with their review forms prolonging the processing time. This delay often results in a tempory disruption in coverage. Recently, the Health Resources Services Administration (HRSA) awarded KHPA a $40.3 million dollar grant under its State Health Access Program. These grant dollars are earmarked to acquire a new automated eligibility system, develop an on-line application process for medical benefits, and hire additional staff to provide outreach and process applications. These additions and the administrative simplifications will pay for creating a more efficient and less daunting system for families to apply for medical coverage.

KHPA is implementing a new internal policy to reduce the churning and disruption to members and providers and to allow for continuity of care. Once the KHPA systems updates have taken place, managed care participants who briefly lose eligibility will be automatically reenrolled with their original MCO retroactively. This should significantly reduce the amount of time when the member is out of managed care and covered by FFS. A completion date for the systems work is tentatively set for mid 2010.

HealthWave Program Demographics

A comparison of beneficiary gender between HW 19 and HW 21 reveals there are proportionally more females enrolled in HW 19. This variation is directly related to the number of pregnant women who are eligible for services under the HW 19 program and by the age limitation for HW 21. The proportion enrolled in HW 19 who are female increased by 1.25% between 2007 and 2008, or approximately 1,500 members. In 2008, 58.75% of HW 19 members were female, compared to 48.73% of HW 21 members, which had an increase in female enrollment of just .25%. This change in HW 19 enrollment most likely contributed to the increased costs experienced by the program in 2008, since actuarial costs and capitation rates are higher for females of child bearing age.

Race and ethnicity are federally mandated data collection elements for Medicaid; however, this information is difficult to collect since it is self-reported by the beneficiary and KHPA cannot compel a person to disclose his or her race. A comparison of race across HW 19 and HW 21 for FY 2005 to FY 2008 reveals a significantly larger percentage of Black or African-Americans enrolled in HW 19 compared to HW 21. This data depicts small changes in the distribution of race over time for both programs. This would suggest a higher percentage of African-Americans in Kansas live within the eligibility thresholds for HW 19, which are lower than the

income limits for HW 21. HW 19 experienced an increase in all populations from 2005 to 2008, with the exception of American Indians or Alaskan Natives, which remained very stable. The population percentages within HW 21 remained stable in all categories.

A comparison of the ethnic distribution across HW 19 and HW 21 populations shows a larger percentage of Hispanic members enrolled in HW 21 than in HW 19; however, Hispanic enrollment shows a steady increase in both HW 19 and HW 21. The data (Table 5) depicts a nearly five percentage point increase in Hispanic enrolllment to both programs from 2005 to 2008. During the same time period, African-American enrollment to both HW 19 and HW 21 has decreased. In 2006 federal citizenship and identification requirements for HW 19 enrollment resulted in a backlog of 20,000 HealthWave applications, explaining most, if not all of the drop in HealthWave enrollment during 2006 and 2007. Separate analysis of the backlog confirms the results below, which indicate that the effort to require documentation of citizenship and identity had the greatest negative impact on African-American enrollment (see the decline in the proportion of HW 19 membership among African Americans) and coincided with an increase in the proportion of Hispanic enrollees.

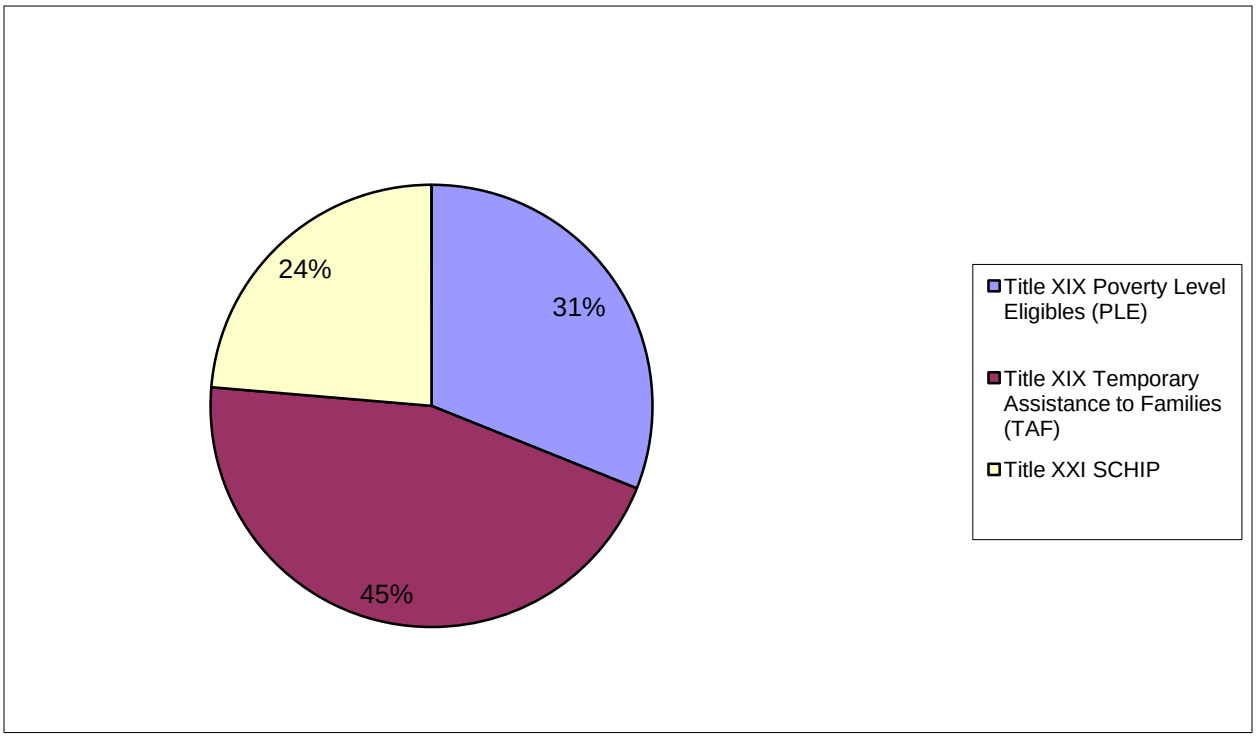
Table 5 - HealthWave Member Ethnicity and Race

HealthWave Member Ethnicity				
HW 19	2005	2006	2007	2008
Hispanic	15.20%	16.15%	18.08%	19.51%
Non-Hispanic	84.80%	83.84%	81.92%	80.49%
HW21	2005	2006	2007	2008
Hispanic	20.17%	21.66%	23.37%	24.85%
Non-Hispanic	79.83%	78.34%	76.63%	75.15%

HealthWave Member Race				
HW 19	2005	2006	2007	2008
American Indian/Alaska Native	1.20%	1.00%	0.79%	0.65%
Black	19.93%	19.38%	18.43%	17.79%
Unknown	4.96%	4.90%	5.06%	5.19%
Pacific Islander	0.05%	0.11%	0.13%	0.12%
Asian	1.39%	1.40%	1.51%	1.60%
White	72.43%	73.21%	74.08%	74.63%
HW21	2005	2006	2007	2008
American Indian/Alaska Native	1.43%	1.39%	1.38%	1.40%
Black	10.13%	9.79%	9.98%	9.63%
Unknown	6.54%	6.68%	6.61%	6.89%
Pacific Islander	0.05%	0.08%	0.08%	0.11%
Asian	1.53%	1.54%	1.59%	1.66%
White	80.32%	80.52%	80.36%	80.31%

HealthWave is composed of members who are eligible for Medicaid (Title 19) under the Temporary Assistance to Families (TAF) and Poverty Level Eligible (PLE) programs, or CHIP eligible members (Title 21). Figure 4 below reflects the breakdown of the total HealthWave population in 2008: 76% of beneficiaries were eligible for care through Medicaid, and 24% through CHIP. TAF income thresholds are the lowest (below 30% of the federal poverty level) and CHIP thresholds are the highest (above 100% up to 150% of federal poverty level). Figure 6 illustrates the concentration of HealthWave participation among the lowest income categories.

Figure 6 - HealthWave Population Distubution by Income Related Eligibility Categories SFY 2008



Service Utilization and Expenditures

HealthWave accounted for approximately 31.2% of KHPA's annual combined Medicaid and CHIP expenditures in 2008, and 54% of the population. Capitation payments represent the total funds distributed by KHPA to the physical health MCOs and the HW 21 mental health MCO. Payments are made to MCOs on a prospective, per-member per-month (PMPM) basis and are used by the MCOs to compensate their network medical providers for services delivered to HW 19 and HW 21 members. Capitation rates in Kansas were originally based on competitive bids provided by UniCare and CMFHP during the contracting process. Now, by contract, rates are actuarially based and updated each year to assure actuarial soundness and to meet regulatory approval by the Centers for Medicare and Medicaid Services (CMS).

Compared to per-capita expenditure for physical health under managed care in the previous one-MCO program, HW 19 experienced savings as a result of the new contract with the two competing MCOs. The negotiated capitation rates were effective January 1, 2007. Capitation rates in 2007 and 2008 were based on fee for service payments for comparable populations, with encounter data and plan financial data supplements. However for FY 2009 KHPA used

actual encounter data from UniCare and CMFHP to base payments. Beginning in FY 2009, HW 19 capitation rates were reduced by another 1.7% due to rebasing (actuarial calculation intended to ensure appropriate reimbursement) and more accurate reflection of the assessment of the provider assessment. HW 21 capitation rates were also reduced by 1.2% due to the move to actuarial based rates (rather than bid rates) that reflect actual utilization trends of the population.

This review of spending through the physical health MCOs focuses on year-to-year trends in the per-member-per-month payments. With the re-contracting process in 2006 and 2007, the competitive bidding process helped generate immediate savings through a reduction in the capitation rates. Trends since 2007 have been favorable and are significantly below external benchmarks for medical cost inflation. Nevertheless, these trends alone are not sufficient to determine the overall impact of the HealthWave program on spending in comparison to the most likely alternatives, such as a pure fee-for-service program, or a fee-for-service program augmented with targeted management interventions. One challenge in estimating HealthWave's impact on spending is that Kansas Medicaid and CHIP no longer have a comparable population receiving care in the FFS program, leaving no direct method to compute savings.

In addition to the services provided by the MCOs, HealthWave members receive additional covered services that are provided seperately from the MCO contracts (i.e. carved out). Some of these services are paid directly to the provider on a FFS basis, while others are paid through a non-physical health capitated managed care arrangement. Examples of carve-out services include:

- Dental: All dental services are provided fee-for-service following a transition from a dental MCO for HealthWave 21 members (Doral Dental) in July 2006.
- Mental Health: Mental health services for Medicaid recipients transitioned from FFS to a capitated program in July 2007.
- Substance Abuse: Substance abuse services for Medicaid recipients also transitioned from FFS to a capitated program in July 2007.
- Local Education Agencies: Reimbursement for therapies and counseling provided to eligible students with individualized education plans has always been reimbursed a bundled rate.
- In-patient hospital for most transplants
- Prescription drugs for the treatment of hemophilia
- All services for presumptively eligible Medicaid and CHIP children

Figures 7 and 8 below depict trends in total program expenditures (MCO payments and expenditures listed above) between FY 2004 and FY 2008. HealthWave expenditure data indicates total HW 19 costs increased from $100 million in FY 2004 to $350 million in FY 2008. The cost increases coincide with enrollment increases of over 90% during the same time period.

HW 21 total costs increased between FY 2004 and FY 2006; however, overall expenditures in FY 2007 and FY 2008 were lower than FY 2006 costs, with per member expenditures decreasing by less than 1%. During the same time period, HW 21 enrollment increased by 16%. Evidently, per person costs in HW 21 were reduced under the new, competitively bid rates negotiated under the new contracts with HealthWave's two MCOs. This suggests that HW 21 rates under the previous contract were not aligned with the health care costs for that population, and may also reflect the benefits of a more competitive procurement with multiple bidders.

Figure 7 - HW 19 Total Expenditures FY 2004 - 2008

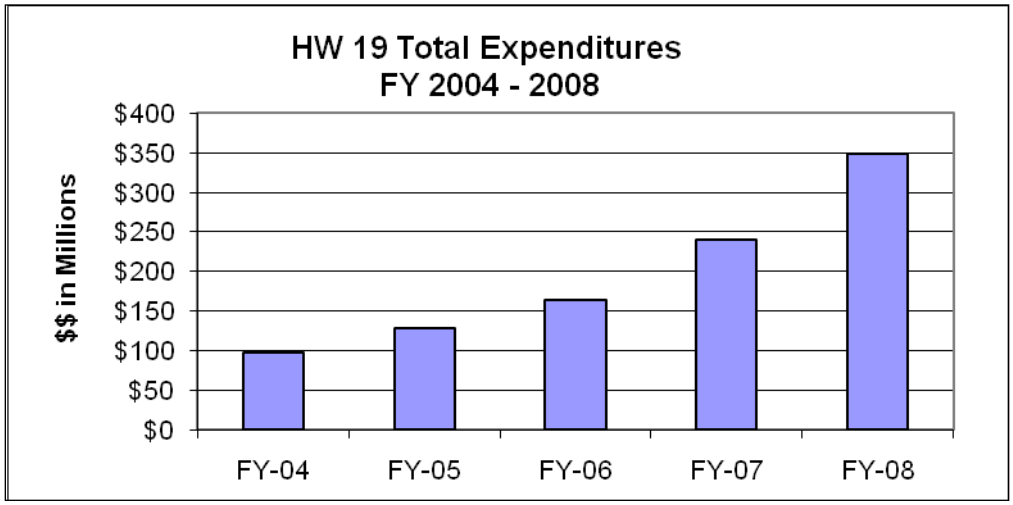
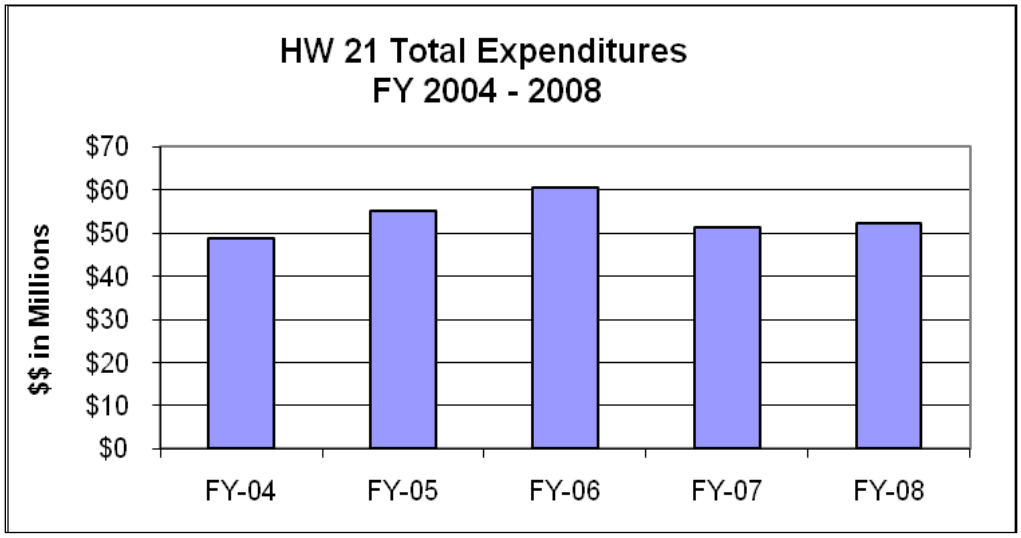


Figure 8 - HW 21 Total Expenditures FY 2004 - 2008



HW 19 and HW 21 both experienced an increase in the average expenditure per member through FY 2006. However, FY 2007 reflects a stabilization in costs for HW 21. This is directly related to changes in HW 19 and HW 21 reimbursement rates negotiated with the new managed care organizations (MCOs). Total costs went up, however, in HW 19 due to the increase in enrollment.

Capitation rates take into consideration the age, gender and geographic region of each beneficiary being covered by an MCO. Because HW 19 covers low income parents as well as children, and the costs for pregnancy are significantly higher than routine care for children, HW 19 payments are noticeably higher than HW 21 payments.

Capitated rates are highest for women aged 22 and older, and for children less than one year of age, populations which comprise a significant percentage of HW 19. To arrive at a plan's total payment, specific capitation rates are multiplied by the number of male and female beneficiaries in seven age categories being covered by a plan in a specific month, as well as two age categories for pregnant women, added to that total is a lump sum delivery payment based on receipt of encounter data documentation. The capitation rates for each combination of age and gender differ across plans because of differences in each plan's original, competitive bid to participate in the HealthWave program. There are also differences in average and total payments to the two plans because the populations enrolled in each plan differ by age, gender, and region.

Pregnant women receive care under HW 19; costs associated with prenatal care and a normal delivery vary slightly by managed care plan, but for FY2008 were approximately $6,000. When HealthWave expanded by 50,000 beneficiaries in 2007, this population included women of childbearing age who were previously covered by HealthConnect Kansas. The number of pregnancies within HW 19 exceeded projections. HW 19 assumed the cost risks associated with the increased number of members who could potentially become pregnant and, therefore, increase program costs, which can account for approximately 17.5% of average monthly capitation payments. A secondary but related factor is the payment structure for prenatal care and subsequent uneventful deliveries. HealthWave follows a common reimbursement policy of paying these services in a lump sum to providers once the beneficiary has delivered. Rather than reimbursing providers for individual appointments leading up to and including delivery plans roll costs into a preset amount that is paid after childbirth. MCOs allow participating providers 180 days to submit claims for payment of all medical care. Large fluctuations can and do occur with pregnancy-related claims because of the length of time from initial prenatal care to the time a provider submits the claim for payment. As a result of the lag time involved and the state's documentation requirements, carryover from 2007 pregnancy-related costs appear as 2008 expenditures.

HealthWave Costs by Type of Plan

Payments to CMFHP and UniCare represent the highest expenditures to the HealthWave program. This is true for both HW 19 and HW 21, with MCO capitated payments accounting for over 85% of total HealthWave costs.

Tables 6, 7, and 8, below illustrate the highest HealthWave expenditures by "Category of Service" as well as displaying the average monthly expenditures for these categories of service for FYs 2005 through 2008. FY 2008 reflects the beginning of a major shift in several categories of service. First, CMS required a reformed payment structure to Local Education Agencies (LEA), which reduced HealthWave expenditures by approximately $5.4 million. Reforms prompted by CMS audits also led the Kansas Department of Social and Rehabilitation Services (SRS) to consolidate Alcohol/Drug Rehabilitation and Community Mental Health Care (CMHC) services for the majority of Medicaid beneficiaries into the PIHP and PAHP, respectively. This consolidation led to a shift in funding for these services that is to be assesssed separately in program evaluation for the PAHP (Overview and Analysis of Kansas Public Mental Health System at http://www.khpa.ks.gov/program_improvements/downloads/MentalHealth_Medicaid%20Transformation%20Report-final%202%202%2010.pdf) and the PIHP (scheduled for review in 2010).

Table 6 - Highest HealthWave 19 & 21 Expenditures

HW 19	FY 2005	FY 2006	FY 2007	FY 2008
MCO	$128,914,529	$164,173,800	$239,489,714	$348,174,093
Dental	8,101,332	9,064,568	13,565,652	17,474,112
CMHC - Mental Health	7,327,698	7,129,657	9,784,818	1,444,895
PAHP - Mental Health				20,439,919
Alcohol/Drug Rehab	2,700,265	2,913,612	3,085,362	339,998
PIHP - Alcohol/Drug				7,811,973
Rehab				
Local Education Agency	7,046,711	7,115,379	9,621,225	4,225,586
Inpatient Hospital	1,665,333	1,258,215	2,058,400	2,776,444
Prescribed Drugs	122,174	530,546	1,552,211	1,370,935

HW 21	FY 2005	FY 2006	FY 2007	FY 2008
MCO – Physical Health	$43,121,097	$48,207,217	$47,053,796	$47,652,523
MCO – Mental Health	$4,493,258	$4,074,013	$4,174,835	$4,533,060
MCO - Dental	$7,495,935	$8,256,623	$22,116	
Dental	200,016	149,312	7,250,081	7,654,112
Prescription Drugs	275,693	222,705	81,903	599,363
FQHC			135,668	187,607

Table 7 - HW 19 Avg. Monthly Expenditures by Categories of Service

	FY 2006		FY 2007		FY 2008	
Category of Service	Consumer Count	Monthly Cost per Consumer	Consumer Count	Monthly Cost per Consumer	Consumer Count	Monthly Cost per Consumer
Managed Care Organizations	117,840	$116.08	179,963	$110.92	193,120	$150.24
PIHP (Substance Abuse)					191,765	$3.39
PAHP (Mental Health)					191,765	$8.88
Dental, Dental Group Practice	29,467	$25.67	43,734	$25.83	55,052	$26.45
CMHC	7,245	$82.08	10,230	$79.67	3,787	$31.84
LEA/ECI	6,529	$90.83	10,532	$76.17	6,489	$54.27
Inpatient Hospital	645	$162.58	504	$341.67	571	$405.20

Table 8 - HW 21 Avg. Monthly Expenditures by Categories of Service*

	FY 2006		FY 2007		FY 2008	
Category of Service	Consumer Count	Monthly Cost per Consumer	Consumer Count	Monthly Cost per Consumer	Consumer Count	Monthly Cost per Consumer
Managed Care Organization Physical Health	56,116	$71.59	55,093	$71.17	56,965	$69.71
Managed Care Organization Mental Health	56,131	$6.05	55,106	$6.31	56,965	$6.63
Managed Care Organization Dental	56,115	$12.26	1,943	$0.95	0	$0
Dental, Dental Group Practice (FFS)	606	$20.50	22,781	$26.50	24,685	$25.84
Prescribed Drugs for Hemophelia	2	$9,279.41	41	$166.40	5	$9989.42
FQHC			799	$14.17	1,211	$12.92

**HW 21 has daily eligibility and prorata payments*

The tables above illustrate several points. First, FFS Prescription Drug costs total nearly two million dollars in 2008 for HW 19 and HW 21 combined, even with very few members utilizing these benefits. The spike in cost is a result of the increasing use of factor drugs for treatment of patients with hemophilia. Second, some costs can be attributed to Presumptive 21 Eligibility. Presumptive Eligibility is a process that allows low income uninsured children under the age of 19 to access health care services from qualified providers while their formal HealthWave applications are being processed. Services that take place during the review period are paid FFS, regardless of the outcome of the eligibility determination. Third, Table 7 reveals a large increase in average per-person costs in HW 19 between FY2007 and FY 2008. Costs are the product of fixed capitation rates, plus pregnancy payments. Previous analysis indicates no major change in the demographics make-up of the HW 19 population, apart from a 1.25% increase in the ration of women to men. Rates in 2008 were lower than in 2007. The increase in overall average costs is largely attributed to the delay in making pregancy payments (pregnancy payments rely on encounter data being shared with KHPA) and to a lesser degree, an increase in the proportion of females participating in HW 19.

A review of HW 19 expenditures by category of service reveals that mental health coverage is the most expensive service outside of capitated payments for physical health care. A separate program review will explore services offered through the state's PAHP, the cost-reimbursed managed care plan overseen by the Department of Social and Rehabilitation Services. Dental care is paid to providers on a fee for service basis, and payment is made only for the actual services delivered. HW 19 provides dental care for children, and in 2008, 55,052 beneficiaries received dental services. Although regular preventive dental care is directly linked to improved overall health status, a significant number of HW beneficiaries do not access care. (See 2008 Medicaid Transformation Dental Program Review at http://www.khpa.ks.gov/medicaid_transformation/download/2008/Chapter%203%20%20Dental%20Services.pdf).

Quality Improvement and Health Plan Oversight

One of KHPA's Vision Principles is ensuring that its participants receive high quality health care that is accessible when and where it is needed. KHPA also has an obligation to ensure that program dollars achieve their intended purpose to improve health and access to care. To this end, KHPA monitors enrollment trends, access to care, expenditures, utilization, and participant satisfaction, as well as other measures that provide an overview of how HealthWave and its contractors are performing.

In response to a lack of comparative data, the 2008 Transformation Plan recommended a significant new effort in health plan oversight and quality improvement. As a result, KHPA restructured its provider and beneficiary (CAHPS – Consumer Assessment of HealthCare Provider and Systems) surveys, as well as other quality measurement tools, in order to allow cross plan comparison and, where possible, regional and/or national comparison. The CAHPS beneficiary surveys allow health care consumers to report on the care they receive from their health care providers and health plans. The survey questions cover topics such as quality, access, and timeliness of care and information provided by MCO customer service staff, office staff, and health care providers.

Members' Rating of HealthWave MCOs v FFS/HCK

The 2008 CAHPS survey allowed for a degree of cross plan evaluation and comparison with HCK; each plan was responsible for contracting with an independent third party to conduct its survey. KHPA contracted with the Kansas Foundation for Medical Care (KFMC), a CMS-certified External Quality Review Organization, to develop and administer the HCK survey, to validate survey methods and results for CMFHP, UniCare, and HCK, and to issue a summary of its findings. The questions used in all three surveys are standardized, with language intended to support comparisons across plans, regionally, and nationally. The plans were allowed the flexibility of adding questions which would give them plan-specific feedback from their members for targeted quality improvement efforts.

Although survey results such as these are sometimes difficult to interpret, we highlight two items specifically in the following chart that stand out, one in commendation to the providers in the plan networks, and one that represents an area of concern to be targeted for improvement. Respondents are consistently happy with their ease of getting care through the health plan, regardless of the plan in which they are enrolled. On the other hand, responses indicate uniformly poor outcomes related to wait times in doctors' offices (see bold responses in Table 9). Another notable point is that parents generally report greater satisfaction for their childrens' care than for their own (see Table 10). This is consistent historically and is in keeping with national trends and may suggest greater access to quality services for children than adults in HealthWave. In general both HW MCOs as well as HCK score well when compared to regional and national data, with pockets of improvement available for all plans. The full comparison report completed by KFMC is available through the KHPA website.

Table 9 – 2008 Child CAHPS Survey Comparison

	Title 19 Child			HW 21 Child		NCBD Regional	NCBD National
	CMFHP	UC	HCK	CMFHP	UC		
Getting Needed Care							
Getting a provider member is happy with Q7	79%	77%	85%	79%	76%	73%	79%
Seeing a specialist Q13	N/A*	N/A	N/A	77%	N/A	68%	69%
Ease of getting care, tests or treatment through health plan Q28	**92%**	**86%**	**85%**	**90%**	**91%**	83%	82%
Ease of getting Health Plan approval for needed care, tests or treatment Q29	93%	97%	96%	96%	97%	X**	X
Getting Care Quickly							
Getting the help or advice needed Q18	70%	65%	68%	72%	72%	69%	64%
Obtaining care right away for an illness/injury/condition Q20	72%	66%	61%	73%	69%	69%	65%
Obtaining care when wanted, not when needed right away Q23	61%	58%	58%	65%	60%	59%	55%
Waiting in the doctor's office less than 15 minutes Q31	**23%**	**30%**	**15%**	**28%**	**26%**	**25%**	**22%**
How Well Doctors Communicate							
Health providers listened carefully Q34	74%	74%	71%	74%	76%	73%	69%
Health providers explained things so child/parent understood Q36	80%	75%	74%	79%	76%	74%	70%
Health provider shows respect for what the child/parent has to say Q37	77%	74%	75%	79%	78%	75%	72%
Health Provider spent enough time with the child Q41	58%	60%	58%	60%	64%	60%	55%
Courteous and Helpful Office Staff							
Office staff treated member with courtesy and respect Q32	79%	80%	77%	81%	78%	80%	74%
Office staff as helpful as member thought they should be Q33	67%	67%	69%	68%	66%	68%	62%
Customer Service							
Finding/understanding information Q79	80%	78%	N/A	76%	76%	72%	76%
The Health Plan's customer service center helpful when member called Q81	75%	N/A	N/A	61%	68%	67%	70%
No problem with paper work for the member's Health Plan Q87	96%	95%	88%	94%	96%	80%	80%
Ratings							
Positive rating of child's doctor or nurse Q5	63%	64%	64%	60%	65%	X	X
Positive rating of child's specialist Q15	N/A	N/A	N/A	57%	N/A	63%	63%
Positive rating of child's health care Q51	73%	69%	68%	68%	71%	X	X
Positive rating child's health plan Q88	70%	67%	73%	67%	69%	55%	62%

*N/A = Denominator less than 100, results not reportable

**X = National CAHPS Benchmark Database results not available

Note- questions have been paraphrased, question numbers (Qx) have been provided for cross comparison

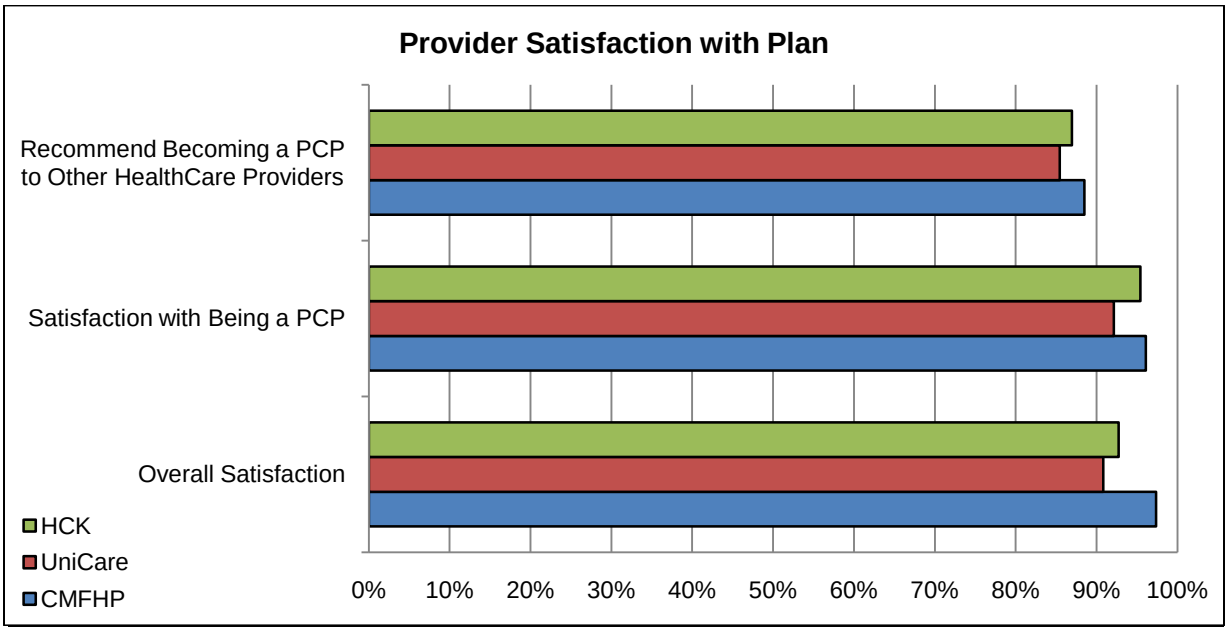
Table 10 - 2008 Adult CAHPS Survey Comparison

	Title 19 Adult			*NCBD Regional*	*NCBD National*
	CMFHP	UC	HCK		
Getting Needed Care					
Seeing a specialist Q23	49%	45%	44%	*49%*	*46%*
Getting care, tests or treatment necessary through your health plan Q27	56%	51%	49%	*54%*	*50%*
Getting Care Quickly					
Obtaining care right away for an illness/injury/condition Q4	66%	62%	52%	*59%*	*57%*
Obtaining care when wanted but not when needed right away Q6	57%	59%	55%	*54%*	*53%*
How Well Doctors Communicate					
Health provider explained things in a way easy to understand Q15	71%	71%	59%	*71%*	*68%*
Health provider listens carefully Q16	72%	70%	64%	*73%*	*70%*
Health provider shows respect for what the member has to say Q17	76%	74%	65%	*76%*	*74%*
Health provider spent enough time with the member Q18	62%	61%	60%	*65%*	*62%*
Customer Service					
Health Plan's customer service provided information the member needed Q31	55%	44%	41%	*51%*	*48%*
Health Plan's customer service treated member with courtesy and respect Q32	72%	89%	54%	*66%*	*66%*
Shared Decision Making					
Health provider discussed the pros and cons of each choice of health care Q10	68%	56%	58%	*60%*	*59%*
If more than 1 choice, did the health provider ask member which was best for them Q11	67%	62%	56%	*57%*	*56%*
Ratings					
Positive rating of personal doctor or nurse Q21	63%	60%	62%	*65%*	*61%*
Positive rating of personal specialist Q25	55%	52%	59%	*62%*	*60%*
Positive rating of health care received Q12	50%	48%	46%	*49%*	*47%*
Positive rating health plan Q35	56%	54%	45%	*53%*	*50%*

Provider Ratings of HealthWave MCOs v. FFS/HCK

During 2008 HealthWave and HCK providers who provided service as a primary care provider (PCP) were surveyed to assess the level of satisfaction within each of the provider networks. This was the first year in which all PCPs in the MCO, FFS and HCK networks received identical provider surveys so cross-plan comparisons could be made. Each questionnaire had a few plan-specific questions. However, all questions were written in a manner allowing for cross-plan comparison, and then analyzed by a third party. Responses were chosen from a four point scale, and satisfaction assessed using the two top answers. For example, Figure 9 indicates the general satisfaction level providers have with their network plans. Providers chose between Strongly Agree, Agree, Disagree, and Strongly Disagree with the two top choices, Strongly Agree and Agree being represented in the charts.

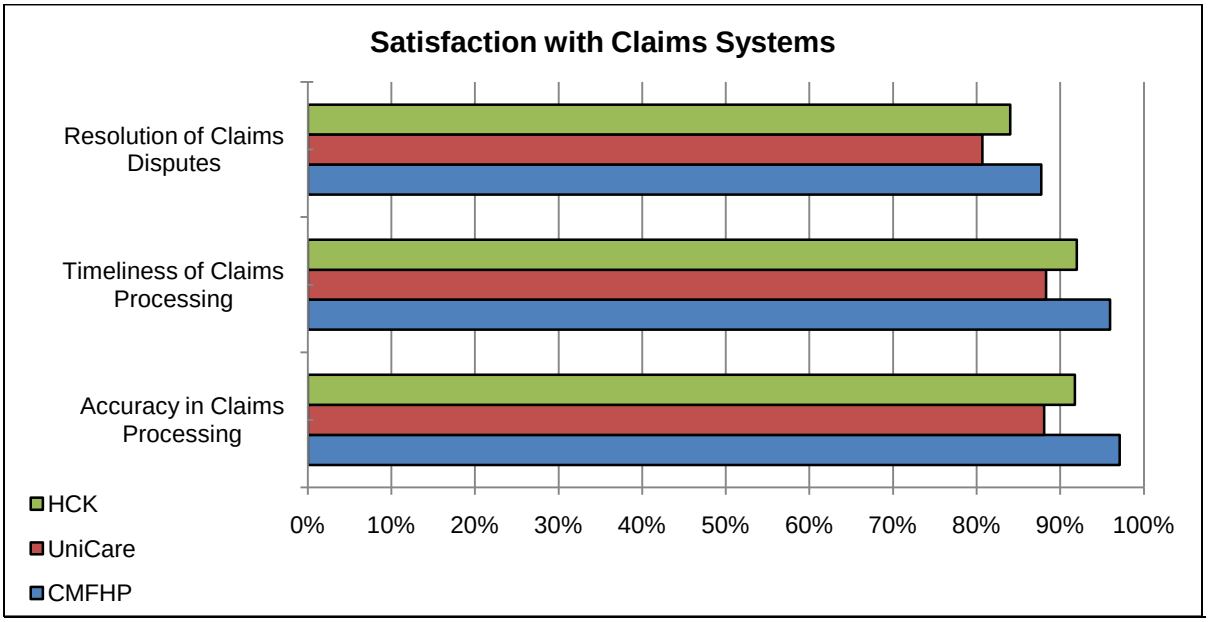
Figure 9 - General Provider Satisfaction with Health Plan



*Responses indicate "agree/strongly agree"

Respondents expressed a general satisfaction with CMFHP, UniCare, and HCK, and over 85% would recommend their respective plans to other primary care providers. Similarly, providers across all plans are generally satisfied with the claims systems of the plans, as reflected in Figure 10, below.

Figure 10 - Provider Satisfaction with Claims System

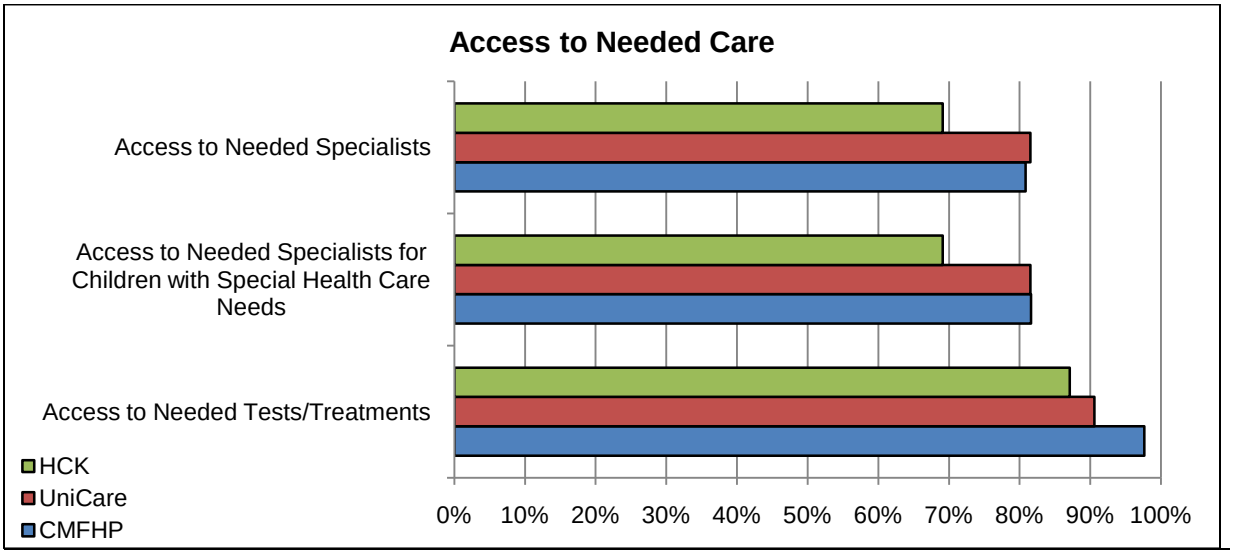


*Responses indicate "somewhat satisfied/very satisfied"

CMFHP tended to slightly out perform UniCare and HCK program in satisfaction with claims payments. KHPA will continue to monitor this measure. The question posed to providers did not ask them to focus their comments on claims payment during the past year. Anecdotal information based on provider complaints to KHPA staff suggests that concerns with payment delays and other problems were concentrated in the first six months of the MCO contracts in 2007. Nevertheless, the difference in plan performance will need further monitoring. One outstanding question is whether these differences in provider perceptions of claims payment processing suggest a corresponding difference in claims cost, e.g., whether providers may prefer one plan over another because of more aggressive care management intervention, more stringent payment criteria, or if providers attribute these differences to other causes. The surveys used in 2008 (and 2009) were not designed to pick up such information.

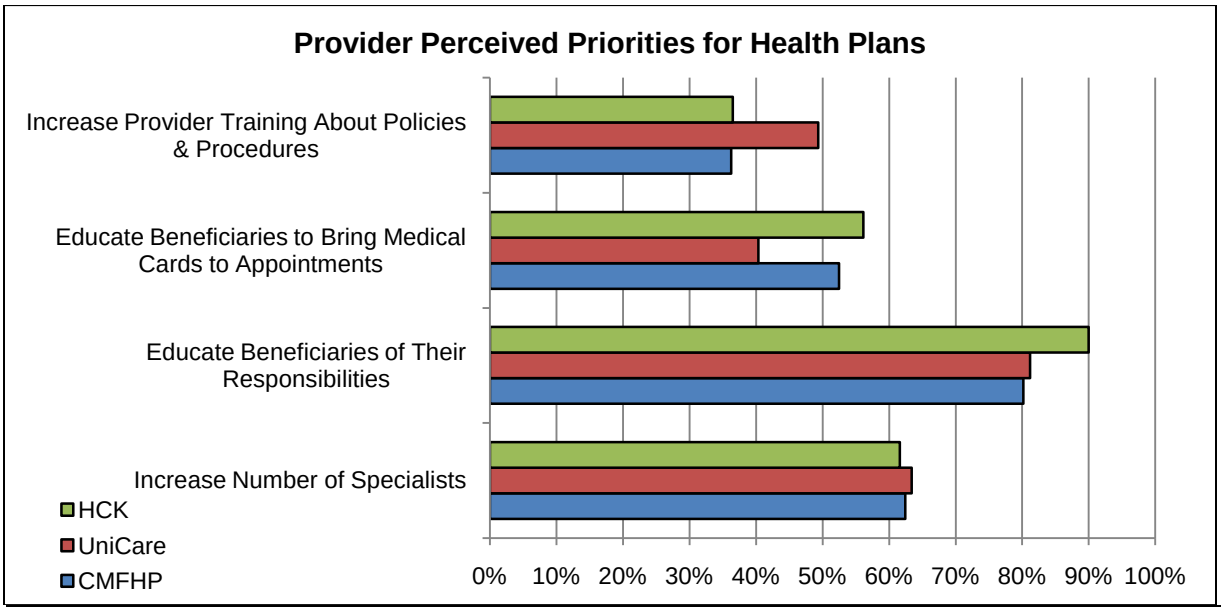
Variances in provider responses are more apparent when examining other aspects of the plans. For example, a noted opportunity for improvement for plans expressed by the provider community is the need for increased access to specialists for beneficiaries. This was evident when looking at Access to Needed Care, Figure 11, as well as Provider Perceived Priorities, Figure 12. Beneficiaries also raised this as a concern through their CAHPS survey responses. (see Tables 9 - 10)

Figure 11 - Access to Needed Care



*Responses indicate "agree/strongly agree"

Figure 12 - Provider Perceived Priorities



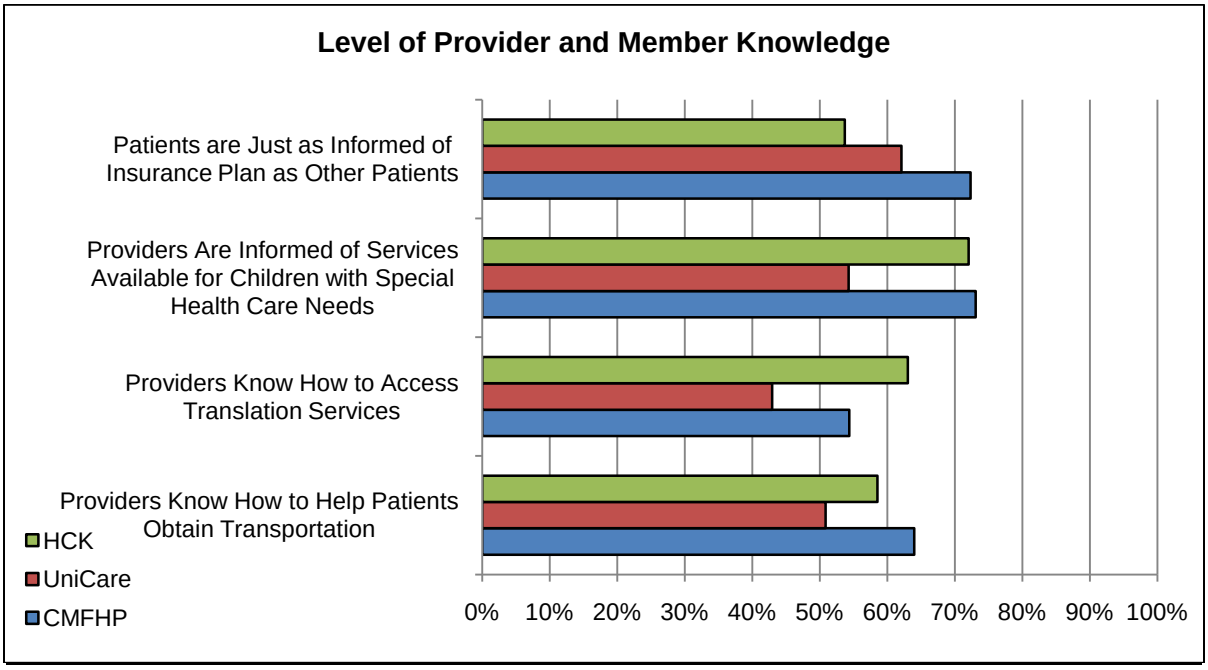
*Responses indicate "medium high/high priority" rating

Providers had an opportunity to comment on the survey questions, and many of the respondents for all plans noted the need to increase member education on the importance of presenting their health plan medical ID cards when arriving for appointments. Medical cards are used to identify the member so that eligibility can be verified through the HealthWave system, and to determine which plan the member is enrolled. Other frequent comments on the provider survey related to dissatisfaction with the new HealthWave medical ID cards, which are not specific to the plans and are outside the control of CMFHP and UniCare. Most of the

complaints about the HealthWave medical ID cards, focused on the lack of MCO plan specifics and eligibility information not printed on the face of the card. KHPA adopted a HIPAA compliant plastic medical card in October 2008, becoming the first state Medicaid program to conform to national standards for advanced ID cards as endorsed by the Workgroup for Electronic Data Interchange (WEDI). This standardization is not confined to Medicaid and most of America's health plans have indicated their intention to convert member cards to this technology. The use of this technology allows any Medicaid provider to "swipe" the magnetic stripe through a card reader to obtain instant eligibility information. The survey results may suggest some divergence between providers' expectation and the growing move by payers to adopt a more uniform standard.

The provider survey illuminated providers' perceptions that HealthWave should improve member and provider education. One section of the survey elicited responses to the level of knowledge providers believe they and their members have on critical health-related issues. Results were mixed at best however, KHPA acknowledges some methodological concern with this section of the survey, which asks providers to offer general statements about the make-up of each plan's membership. The results of the survey could be due to differences in plan performance, e.g., in educating their members, but could also be due to differences in the composition of each health plan's membership, e.g., older, younger, or more or less amendable to a plan's educational effort.

Figure 13 - Level of Provider & Member Knowledge

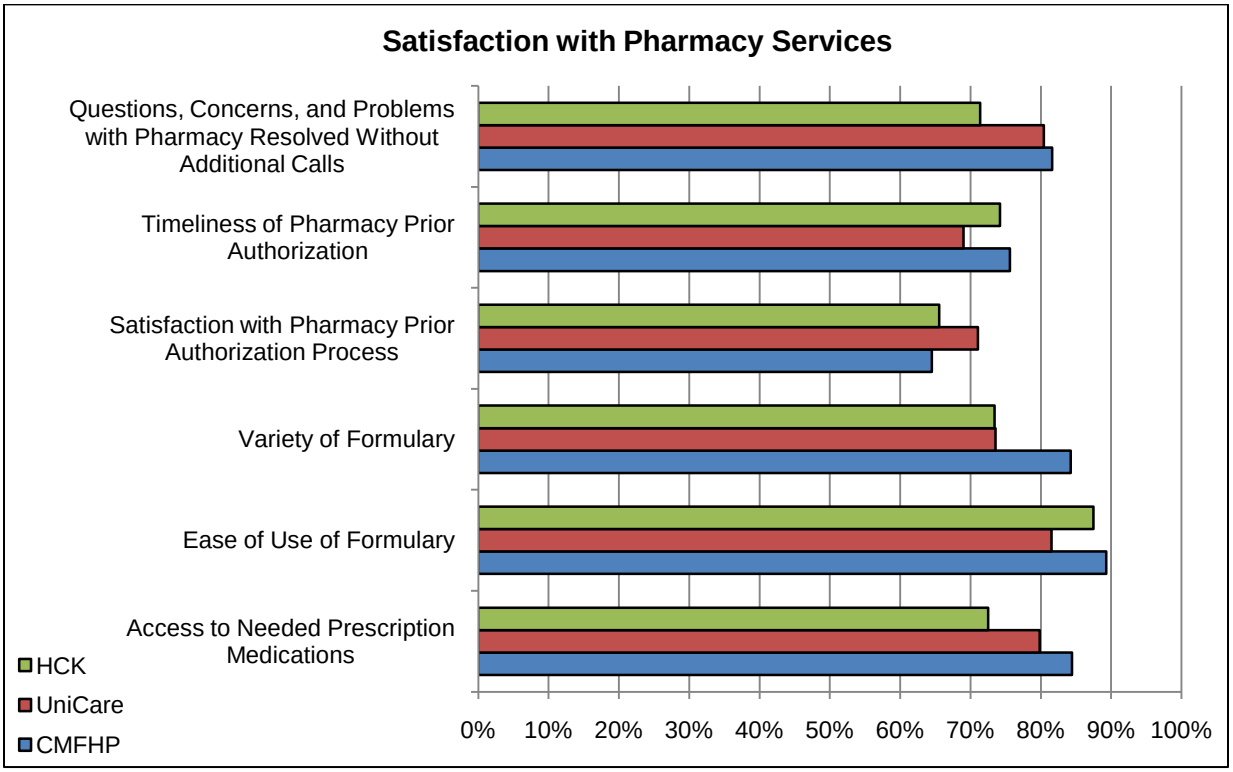


*Responses indicate and answer of "yes"

Providers and the health plans spend a significant amount of time managing the pharmacy needs of their members and pharmacy comprises a significant percentage of HealthWave costs. The provider survey included a section on pharmacy services to determine the plans' performances. These are reflected in Figure 14. Results suggest providers generally find easier access to prescriptions of choice under CMFHP's pharmacy plan. KHPA does not have plan-

specific financial data to indicate whether CMFHP's more attractive management of pharmacy results in higher or lower pharmacy costs than Unicare. A new data system currently being implemented is expected to make such comparisons possible.

Figure 14 - Satisfaction with Pharmacy Services



*Responses indicate "somewhat satisfied/very satisfied"

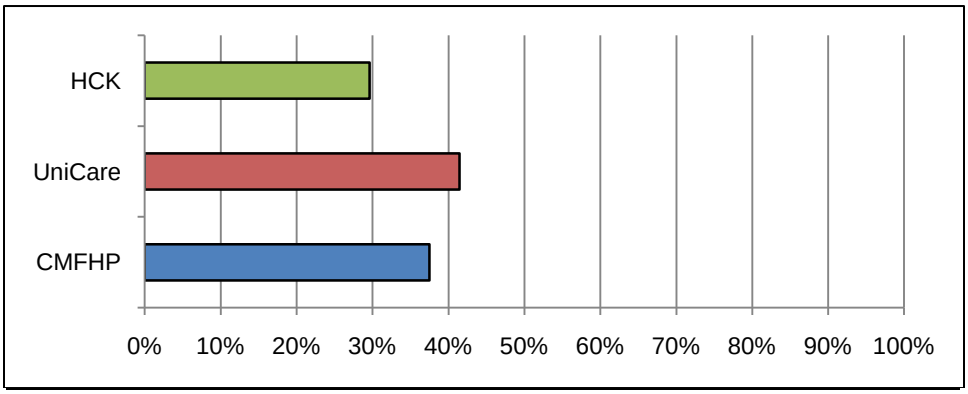
Generally, all plans are perceived to have a formulary that is easy to use, and to have a satisfactory issue resolution process in place. However, the prior authorization process is one common area for all plans where providers responded with lower satisfaction rates. Athough the MCOs manage their pharmacy programs independently, they both operate under the same stipulations required for FFS, such as having an open formulary that includes every drug included in the federal rebate program, and having no restrictions on mental health drugs.

As part of the provider survey, providers were asked if they participate in the Kansas Vaccines for Children (VFC) program, a federal initiative administered through the Kansas Department of Health and Environment (KDHE). The VFC program provides vaccines at no cost for children who might not otherwise be vaccinated because of inability to pay and was implemented in Kansas in October 1994. VFC distributes vaccines at no charge to private physicians' offices and public health clinics registered as VFC providers. KHPA and its MCOs strongly encourage providers to participate in VFC for two primary reasons: having the cost of the vaccines covered by VFC rather than Medicaid, and more importantly for beneficiaries, having continuity of care. Specifically, providers who do not participate in VFC and who refer HW 19 and HW 21 children to VFC providers for inoculations cannot ensure that the children they care for receive timely and necessary vaccines without having a reliable tracking and follow up system in place. In addition flu vaccines, including those for H1N1, are included in the VFC program. Many of the

safety net providers and health departments were flooded with persons requesting this immunization. Increased participation in the VFC program can assist the public health system in more quickly and evenly distributing vaccine across the medical community in the case of a pandemic and decrease the burden on the health departments and safety net clinics.

The following figure demonstrates that both MCOs and HCK have low provider participation rates in VFC. Better coordination among state agencies and the health plans, and improved outreach to providers is necessary to raise the overall participation rate in the VFC program.

Figure 15 - Vaccines for Children Participation



*Responses indicate and answer of "yes" when asked if they are a VFC provider

Both the annual provider and beneficiary surveys indicate that a consistent weakness to the HealthWave program is the lack of availability to specialty providers. Less than 50% of HealthWave adult members believe they receive adequate specialty care; and although over 80% of the provider survey respondents stated that the MCOs offer access to needed specialists, over 60% considered increasing the number of specialists as a priority for the health plans. KHPA and the MCOs will work in the coming year to determine where shortages exist and develop options for expanding access.

Direct Measures of Quality using Administrative Records

In addition to the provider and member surveys, KHPA uses other tools to determine how well the contracted plans perform. Despite the acknowledged limitations of claims-based measures of quality, the Healthcare Effectiveness Data and Information Set (HEDIS) is an instrument used by more than 90 percent of health plans in the United States to measure performance on important dimensions of care and service. KHPA recognizes the importance of utilizing standardized comparable performance tools, and accordingly, has mandated that the MCOs annually submit outcomes of their HEDIS performance measures for review. The reports must be stratified for Medicaid Title 19, CHIP Title 21, and for Children with Special Health Care Needs (CSHCN). Health plans must submit their HEDIS data collection methods and results, which are reviewed and validated by KFMC and objectively reported to KHPA. KFMC's reports consist of summaries and completed assessment tools that meet the CMS protocol for validating performance measures. The reports' conclusions identify the plans' strengths as well as opportunities for improvement in regard to the accuracy of how each MCO reported its data and the outcomes of the data.

The HEDIS measures chosen by KHPA for oversight of the Managed Care Contractors are a combination of administrative and hybrid performance measures. Hybrid measures require a combination of administrative data and data collected through clinical record reviews. The Performance Measurement Validation reports for CMFHP and UniCare drafted by KFMC may be accessed through the KHPA website; however, Table 11 provides a side by side plan comparison with national averages of all reporting health plans for the HEDIS measures preselected by KHPA.

Table 11 - 2007 HEDIS Rates

	National Average (2007)	CMFHP HW19	UniCare HW19	CMFHP HW21	UniCare HW21
Children and Adolescents' Access to Primary Care Practitioners 12-24 months	94.1%	88.27%	**95.22%**	89.77%	97.89%
Children and Adolescents' Access to Primary Care Practitioners 25 months - 6 years	84.9%	83.25%	**87.24%**	82.35%	88.22%
Adults' Access to Preventive/Ambulatory Health Services 20-44 years	78.2%	75.06%	**82.72%**	N/A**	N/A**
Adults' Access to Preventive/Ambulatory Health Services 45-64 years	83.1%	78.55%	**91.00%**	N/A**	N/A**
Well Child Visits (3 - 6 years)	66.8%	**71.32%**	58.33%	67.86%	54.40%
Prenatal Care	81.2%	**83.94%**	37.96%*	–	–
Postpartum Care	59.1%	58.39%	37.96%*	–	–
Comprehensive Diabetes Care - HbA1c Testing	78.0%	**81.54%***	63.55%*	–	–
Comprehensive Diabetes Care - HbA1c Poor Control >9%	48.7%	68.72%*	71.96%*	–	–
Comprehensive Diabetes Care - HbA1c <7%	30.2%	19.49%*	11.21%*	–	–
Comprehensive Diabetes Care - Eye Exam	51.4%	36.41%*	14.95%*	–	–
Comprehensive Diabetes Care - LDL-C Screening	71.1%	63.59%*	41.12%*	–	–
Comprehensive Diabetes Care - LDL-C Level <100	30.6%	13.85%*	7.48%*	–	–
Comprehensive Diabetes Care - Nephropathy Monitoring	74.6%	60.51%*	67.29%*	–	–
Comprehensive Diabetes Care - BP < 130/80	30.4%	18.46%*	14.02%*	–	–
Comprehensive Diabetes Care - BP < 140/90	57.3%	37.44%*	25.23%*	–	–

Note: Data prepared using 2007 administrative data in conjunction with chart review when necessary.

*Areas of improvement identified by plans for Performance Improvement Projects.

**HEDIS Measure for adults only, not applicable to the CHIP Program.

– Sample size too small to provide a result that would be representative across a plan.

Several measures in which the plans exceeded the National Average are indicated in green in Table 11 above. Preliminary HEDIS results from 2008 (not shown) suggest overall improvement in plan performance, but the initial results shown above from 2007 raised concerns. Of note; both plans showed lower than national average results in Comprehensive Diabetes Care (Comprehensive Diabetes Care - HbA1c Poor Control >9%). As a result, KHPA instructed UniCare and CMFHP to improve care for this disease state. The MCOs chose to collaborate in a statewide Performance Improvement Project (PIP) to improve their overall care to beneficiaries with a diagnosis of Diabetes. The (PIP) will measure 10 well-defined HEDIS indicators included in the Comprehensive Diabetes Care measure, and interventions will focus on provider support. Outreach to providers with patients with a Diabetes diagnosis will occur in two steps. Results from this PIP should be evident when 2010 HEDIS data is collected.

Plan-Specific Reviews

KHPA program managers are assigned to oversee the state's contracts with its MCOs, and they utilize a number of tools to assess the plans' performance. Using the results of the CAHPS and Provider Surveys, HEDIS rates, and CMS audit results are in part how program managers assess the performance of the MCOs; however, the level of oversight is more robust. KHPA program staff communicate daily with MCO staff about operational and quality matters, and regularly monitor reports that provide details about how well the plans are caring for their members. Table 12 illustrates some of the regular reports the plans submit to KHPA for monitoring.

Table 12 - 2008 Quality Reports

Plan	Report Type
Monthly	
UniCare, CMFHP, CBH	Provider & Member Customer Service Call Center
UniCare, CMFHP, CBH	Claims
UniCare, CMFHP	Provider Network
CBH	Provider Directory
UniCare, CMFHP, CBH	Provider and Member Grievances & Appeals
UniCare, CMFHP	Provider and Member Fraud & Abuse
UniCare, CMFHP	Member Lock-In
UniCare, CMFHP	Emergency Room Utilization
UniCare, CMFHP	Admissions/Precertifications
UniCare, CMFHP	Pharmacy, Rankings by Volume of Prescriptions Paid & Amounts Paid
UniCare, CMFHP	Fair Hearings
UniCare, CMFHP	KanBeHealthy/EPSDT Screenings
Semi-Annually	
UniCare, CMFHP	Blood Lead Testing
UniCare, CMFHP	Performance Improvement Projects
UniCare, CMFHP	Provider Utilization
UniCare, CMFHP	Provider Profiling
UniCare, CMFHP	Income & Expense

Annually	
CBH	Financial Summary
UniCare, CMFHP	Evaluation of Access to Care
UniCare, CMFHP	Quality Improvement Workplan
UniCare, CMFHP	Quality Improvement Evaluation
UniCare, CMFHP	Provider Profiling
UniCare, CMFHP, CBH	Quality Improvement/Utilization

In addition to regular reports, each MCO undergoes an annual audit where KHPA staff review policies, procedures, and practices of the plan to ensure that it complies with contractual obligations and is notified of any areas that do not meet KHPA's expectations. Those audit results, as well as relevant information from some of the above reports are included in the plan-specific reviews.

MCOs are also required to submit their claims payment data, including both paid and denied claims, to the fiscal agent. These claims, called encounter data, are then processed through the fiscal agent's claims engine and stored for use in a number of activities such as rate setting, MCO oversight, quality improvement efforts, and for inclusion in numerous reports for CMS. During the fall of 2008, KHPA led a review of this data and identified a number of issues with the data that limited its usefulness in these critical areas. KHPA has worked with the MCOs to purge the incorrect data and import new encounter claims to improve the accuracy of the data. This data will then be exported to the Data Analytical Interface (DAI) for comparison to Medicaid fee-for-service, state employee benefit health plan, and information from the Kansas Health Insurance Information System (KHIIS contains data that represents information from all insurance companies in Kansas).

Children's Mercy Family Health Partners

Children's Mercy Family Health Partners (CMFHP) is a local, Kansas City based nonprofit organization that provides care to approximately 68%, or roughly 110,000, HealthWave participants. HealthWave beneficiaries residing in Regions 1 and 2 may choose either CMFHP or UniCare as their health plan. Since 2007, when KHPA expanded HealthWave and contracted with CMFHP as one of its two physical health MCOs, these enrollment percentages have remained fairly consistent.

MCOs are contractually required to conduct two annual Performance Improvement Projects (PIPs), in a proactive effort to increase the quality of service provided by the MCO. KHPA approves all PIPs, and at times direct the MCOs to focus on particular topics. CMFHP's initial PIP focused on childhood lead screening. Based on the MCO's previous experience working with Medicaid children in Missouri, CMFHP implemented similar interventions for their HW members. CMFHP encountered challenges with receiving consistent information from their initial external data source, which resulted in a delay in the study. However, preliminary results after initial interventions show a modest 2% improvement in lead screening rates. The study will continue through CY2009, with final results being published in CY2010.

More recently, PIPs for CMFHP were based on 2008 CAHPS survey and 2007 HEDIS results, responding to areas where data indicated opportunities for improved performance. One PIP will be conducted independently, as was the lead screening PIP in 2008; the study topic is improving members' perceptions of Customer Service, and is based on results of the 2008

CAHPS survey and subsequent recommendation by CMFHP's Administrative Oversight Committee.

The second PIP will be carried out in collaboration with UniCare. As previously noted, both plans are working together to improve the HEDIS rates for Comprehensive Diabetes Care. Given the prevalence of diabetes and the devastating complications of the disease, KHPA identified the need for positive change and improved outcomes in diabetic care to HW members. Quality improvement staff from UniCare and CHFHP held joint planning sessions to develop one set of interventions that both plans will use.

UniCare Health Plan of Kansas

UniCare Health Plan of Kansas (UniCare) is a national company and affiliate of WellPoint Health Networks Inc. Unicare is one of the nation's largest publicly traded managed care companies with more than 35 million members, approximately 1.8 million of those receive Medicaid. In Kansas, UniCare provides services to approximately 32% or approximately 51,000 HealthWave beneficiaries who reside in Regions 1, 2, or 3 and are eligible for managed care. As HealthWave enrollments continue to increase UniCare enrollments do, as well, topping 51,000 members at the end of 2008. UniCare's market share of 32% has remained relatively consistent since it began serving HealthWave beneficiaries in 2007.

UniCare's initial PIP focused on improving the rate of adolescent well–visits. In 2005, the National Ambulatory Medical Care Survey indicated that only 8% of office visits for patients 13-21 years of age were for routine well checks. The 2006 Medicaid national average for adolescent well visits for this age group was 40.33%, and the overall HEDIS rate for this measure was 55.32%. These rates were the basis for UniCare selecting this study topic for its first PIP. UniCare chose a target group as a pilot for its interventions. Twelve counties from the Southeast region were selected because all are rural counties and because 10 of the 12 have median household incomes that were below the Kansas median income level. The target group represents 7% of UniCare's PCP population, 10.72% of its HW 19 adolescent population, and 8.36% of its HW 21 members aged 13-21. The study date for this PIP runs through the end of CY 2009. Interventions consist of UniCare staff calling, visiting provider practices, or both; during the phone call or visit, the providers are given HEDIS measure requirements to ascertain if well visits are being properly documented. UniCare staff also offer reminders of the importance of preventive care visits, as this particular measure has a strong association for health outcomes. Additional interventions will be based upon the results of a mid-PIP analysis which has not yet been completed.

KHPA expressed concern regarding the 2008 HEDIS results, prompting UniCare to present its 2009 PIPs for KHPA approval The PIPs directly relate to areas where data indicated opportunities for improved performance. UniCare is focusing its independent PIP on improving the rates of prenatal care in the first trimester and of postnatal care, two areas where 2008 HEDIS results showed a need for improvement. The second PIP focuses on improving comprehensive Diabetes care in partnership with CMFHP. This teamwork will allow comparisons between the plans once the study is completed, and will also assist providers by ensuring that they receive consistent educational support from both UniCare and CMFHP.

Cenpatico Behavioral Health

Cenpatico Behavioral Health (CBH) is a for-profit company established in 1994 as a managed behavioral healthcare organization. In 2006, KHPA contracted with CBH to provide mental

health care services to HW 19 beneficiaries. CBH specializes in focused care management for Medicaid and CHIP members, especially those at risk of mental health disorders. CBH is paid a capitated rate to provide behavioral health services through a managed care structure. KHPA monitors the contract with CBH by requiring regular claims and utilization data reports. In July 2008, KHPA revised the claims reporting requirements for its MCOs. CBH, along with the physical health MCOs changed its report format to match KHPA requirements.

From a customer service perspective, CBH telephonic service performs better than industry standards. Although some fluctuation has occurred since 2006, of the four outcomes tracked, CBH performance in 2008 was far superior to the established benchmarks. Of particular note was the call abandonment rate for "after hours" phone calls, which dropped to less than 1%. During non-business hours, all telephone calls divert to NurseWise, a nurse triage service. NurseWise representatives can provide eligibility verification and participating provider status, and receive notification of inpatient admissions. After hours crisis calls are transferred to a licensed CBH employee.

In 2008, CBH fielded their own member satisfaction survey, however due to poor response rates, the survey was unreliable. KHPA directed CBH to improve the reliablity of this survey. In response, CBH contracted with an external company, The Myers Group, to independently field a satisfaction survey. Results of this survey will be available in the 2009 HW review and through the KHPA website.

CBH began intensive case management (ICM) services in 2008 for HW 21 members who are at high risk of contending with mental health disorders. ICM focuses on reducing readmissions and increasing compliance with 7-day and 30-day follow up post hospital discharge. Several ICM interventions focus on improved discharge planning and post discharge follow up. CBH staff contact hospitals immediately upon admission of a HW 21 member to provide the hospital with necessary information about previous outpatient treatment and to assist with the discharge planning process. CBH staff communicate with parents/guardians during the inpatient stay to assist with identifying and addressing potential barriers to post discharge care and locating appropriate community supports. CBH also works with members to ensure that post discharge follow up appointments and treatments are scheduled and that members are able to access the planned care. Members who do not attend their follow up appointments are contacted by CBH staff, who assist the members with rescheduling their follow up care. Primary care providers and outpatient behavioral health providers are contacted by CBH, as well. These outpatient providers receive the hospital discharge summary, in an effort to promote better continuity of care and collaboration among all providers.

ICM outcomes are tracked by the quarter of member enrollment, and utilization activity is analyzed for those members maintaining 30, 60 and 90 days of ICM enrollment.

Of the total number of HW 21 members enrolled in ICM during the first three quarters of 2008 (124), 82 maintained enrollment for at least 30 days (66.1% retention rate). Of these members, inpatient admissions and bed days were greatly reduced from pre-enrollment in ICM. Inpatient admissions dropped from 141 admissions in 2007 to 83 in 2008. Of the 83 admissions in 2008, 63 were enrolled in ICM. While the average length of stay increased by 28.5% for these members, community tenure (days in the community instead of inpatient) increased due to a decline in readmission. This suggests that hospitalizations that did occur were longer and were medically necessary to stabilize the member, thus not requiring readmission.

Table 13 - 2008 ICM 30 Day Enrollment, First Three Quarters

82 members (66.1% retention)	30 Days Pre-ICM	30 Days Post-ICM	Variance
IP Days	324	57	82% reduction
Total Admissions	66	9	86% reduction
Average Length of Stay	4.9	6.3	28.5% increase
Community Tenure	86.8%	97.7%	11% increase
Medical expenses per day	$1930.59	$748.63	61% reduction
Medical expenses per member	$2118.94	$821.67	61% reduction

Only 40 members (32.3%) maintained enrollment in ICM for at least 60 days however these members continued to experience lower inpatient utilization and medical costs. Average length of stay rose to 8.1 days. Community tenure continued to increase to 97%.

Table 14 - 2008 ICM 60 Day Enrollment

40 members (32.3% retention)	60 Days Pre-ICM	60 Days Post-ICM	Variance
IP Days	158	73	54% reduction
Total Admissions	29	9	69% reduction
Average Length of Stay	5.4	8.1	50% increase
Community Tenure	93.4%	97.0%	4% increase
Medical expenses per day	$508.50	$321.11	37% reduction
Medical expenses per member	$2288.25	$1445.47	37% reduction

Sustained enrollment in ICM for at least 90 days dropped to 19.4%, although utilization rates continued to decrease. Average length of stay increased 45% from pre-enrollment to 8.1 days. Medical expenses show an increase after 90 days of enrollment suggesting that the small number of members maintaining enrollment for 90 days are more acutely ill, which warrants increased treatment for a population of members that are most vulnerable and need the greatest level of intervention.

Table 15 - 2008 ICM 90 Day Enrollment

24 members (19.4% retention)	90 Days Pre-ICM	90 Days Post-ICM	Variance
IP Days	95	57	40% reduction
Total Admissions	17	7	59% reduction
Average Length of Stay	5.6	8.1	45% increase
Community Tenure	93.4%	97.0%	4% increase
Medical expenses per day	$180.59	$220.59	18% increase
Medical expenses per member	$2031.68	$2481.61	18% increase

As sustained enrollment periods increase, the ICM retention rate decreases. This can be attributed to members enrolled in ICM successfully reaching their goals, which lowers their risk and allows them to discontinue ICM. Often times, a member can move out of ICM because the family receives education and support, as well as assistance with identifying an appropriate provider to manage the member's care. Members enrolled in ICM for longer periods are typically very high risk and in need of continued intensive intervention, and often require more frequent inpatient care. Costs are higher for those members who receive 90 days sustained enrollment, because there are fewer members who require a higher (and therefore more costly) level of care.

Although ICM is a service provided specifically for HW 21 members at high risk of complex mental health disorders, CBH provides access to behavioral health care for the entire HW 21 population. Utilization outcomes are mixed for HW 21 as a whole than they appear to be for members receiving ICM. The average length of stay for inpatient care rose from 3.9 days in 2006 to 4.3 days in 2007 and 2008. These rates fall within acceptable range and below 4.4 days, which was set as a benchmark when compared to historical utilization patterns. (Figure 16) Seven day and 30 day follow-up care for HW 21 has dropped since 2006, and in 2008 fell below benchmarks for both measures. Follow up within 7 days shows the biggest disparity between actual utilization and benchmarks (Figures 17 and 18). Perhaps as a result of enrolling members into intensive case management, 30-day readmission rates for inpatient care has dropped by nearly 50% since 2006 (Figure 19).

CBH is engaged in a Performance Improvement Project in an attempt to improve rates of follow-up care following an inpatient event, that was approved by KHPA. Initial interventions included contacting parents during hospitalization to discuss discharge plans and follow up care, reminder phone calls prior to the follow-up appointment, contacting the provider to verify that appointments were kept, adding in-home service providers to the provider network, and coordinating transportation services. CBH will add interventions such as enhanced provider engagement including primary care providers and hospital discharge planners, developing an enhanced discharge toolkit for members and their families, and initiating "Caring Voices" which provides cell phones to members who do not have a reliable method for contacting providers, and other supportive resources.

Figure 16 - Inpatient Avg. Length Stay/Days for Mental Health Diagnoses

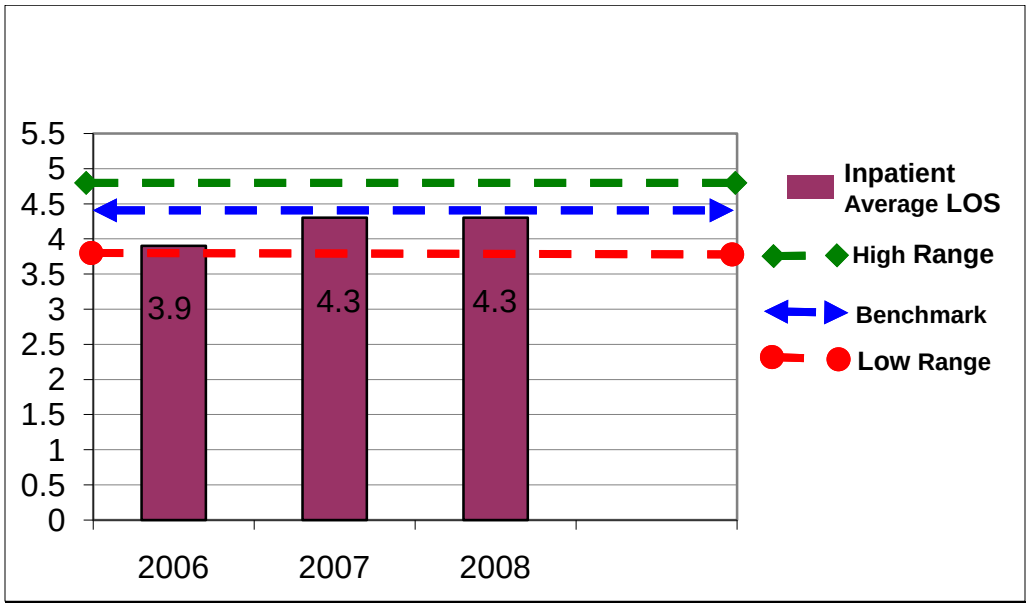
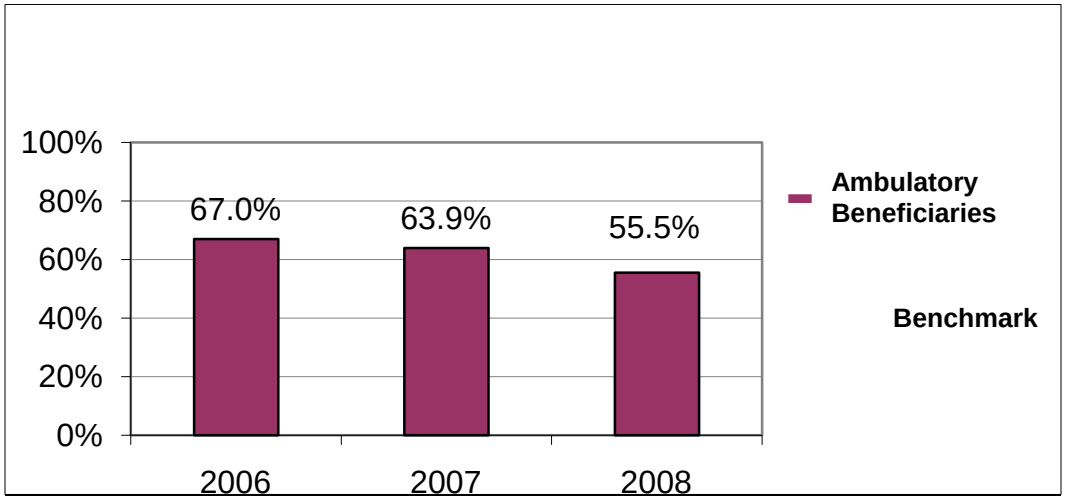


Figure 17 - Ambulatory Beneficiaries with Follow-up Within 7 Days for Mental Health



A second and related Performance Improvement Project focuses on post-hospital safety for children to improve the rates in which members receive appropriate and timely follow up care. Anecdotal evidence collected through communication between CBH's care coordinators and parents suggests that rather than following appropriate follow-up care protocols of having at least one provider visit with a psychiatrist for medication management and two therapy sessions within 60 days of discharge, children utilize after care services at schools and are less likely to visit a psychiatrist and attend therapy. Interventions aimed at improving psychiatric care and therapy include incentives for both the child and parents and developing a method for documenting the services schools are providing post hospital discharge.

Figure 18 - Ambulatory Beneficiaries with Follow-up within 30 Days for Mental Health Diagnoses

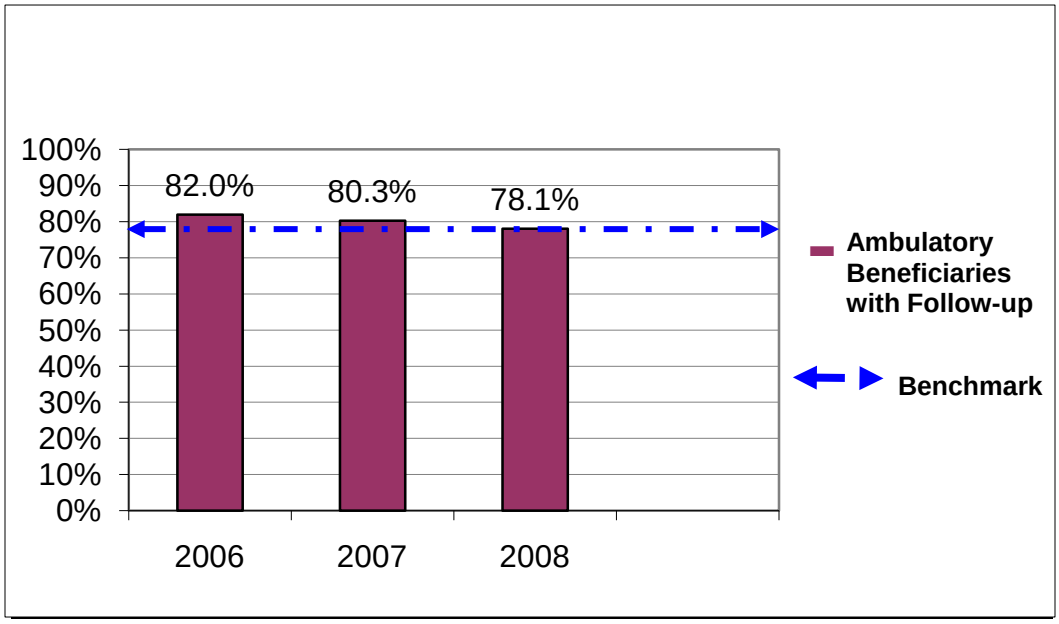
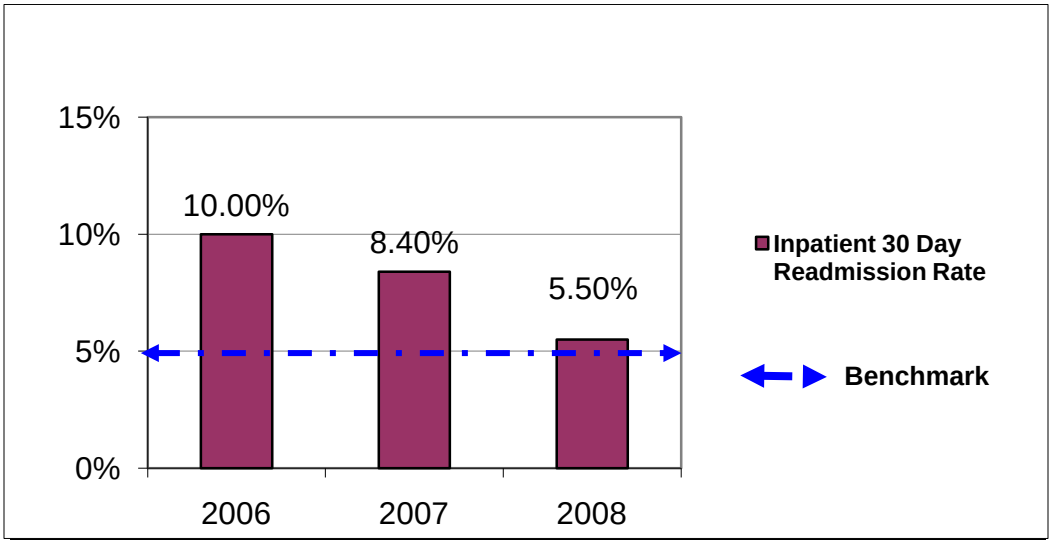


Figure 19 - Inpatient 30-Day Readmission Rate for Mental Health Diagnoses



CMS Review

In April 2008, CMS performed an onsite review of Kansas CHIP and Medicaid Managed Care programs. During this visit CMS reviewed KHPA adherence to several items: federal laws and regulation; CHIP eligibility determination process; KHPA contract management practices; internal MCO practices; member notifications processes; and KHPA reporting to CMS. Overall, the CMS response was very positive and productive. CMS identified a number of "noteworthy practices," presented "recommendations" for improvements, as well as a few "findings" requiring action.

One recommendation from CMS was for KHPA to improve its method of collecting information on payment of claims from the plans. In July 2008, KHPA directed the plans to begin submitting a new claims report that depicts the number and value of claims processed within 30, 60, and 90 days of receipt. The claims are separated by claim type: inpatient, professional, pharmacy, and include claims that are paid, denied, and/or suspended within the given timeframes. In conjunction with a quarterly claims report that shows average number of days to pay, this new report allows KPHA staff to monitor claims reports and ensure timely payment to providers.

Another collaborative effort that includes both physical health MCOs, the mental health and substance abuse MCOs, KHPA, and SRS is a coordination of care initiative that is focusing its first phase on pregnant women. This multiagency effort is designed to streamline the process of getting needed care quickly to beneficiaries who may have cross-discipline needs when they arrive at a provider's site. Through improved coordination among MCOs and better provider support, medical staff will have better information about who to contact for coordinating care for beneficiaries who present with physical health needs in conjuntion with mental and or substance abuse needs. Better coordination should lead to timely, appropriate care, and ultimately, better health outcomes.

The CMS audit cited several examples of noteworthy practices, including the method KHPA uses to monitor the health plans. KHPA's Contract Managers use contract monitoring logs as a tool to track receipt of MCO contract deliverables. For each contract deliverable the log lists the due date, the MCO staff person responsible for submission, the KHPA staff person to whom the

deliverable should be submitted, and the actual submission date. Additional noteworthy practices recognized by CMS are detailed below:

MCO Use of Grievance Data for Process Improvement

- UniCare and CMFHP describe the grievance system in member materials so that members understand how to file a grievance
- UniCare and CMFHP maintain internal grievance system procedures and report quarterly grievance data to KHPA
- CMFHP used grievance data to detect performance deficiencies with its non-emergency medical transportation (NEMT) subcontractor, which led to an investigation and a subsequent change in transportation vendors.

CMFHP Member Services

- Sends reminder postcards for well-child visits, immunizations, lead screenings, mammograms, and well-woman and well-man check-ups
- Provides health management classes for members with chronic conditions Provides toolkits to parents for use in encouraging healthy eating and exercise habits in their children
- Provides face-to-face interpreters at medical visits for non-English speaking members, when requested.

UniCare Member Handbook

- Provides helpful information on asthma, diabetes, smoking, and childbirth as part of its member handbook, with clear instructions on how to receive additional information
- Provides MedCall, a toll-free 24-hour nurse helpline telephone number listing at the bottom of every page of the member handbook for easy reference
- Uses symbols throughout the member handbook to draw the reader's attention to helpful phone numbers, important information, services that require prior authorization, and information that is of special interest to women and to parents of infants.

Conclusion

During 2008, KHPA and MCOs focused on establishing a quality improvement process for the HealthWave program, and used that process to identify specific areas of improvement in the quality of care provided its members. This process included a comprehensive quality assessment of the managed care plans using a combination of industry standard tools such as Consumer Assessment of Health Plan Survey (CAHPS), Health Effectiveness Data & Information Set (HEDIS) measures, and internally-developed tools such as the Provider Satisfaction Surveys. Through these measures, KHPA and the MCOs were able to identify areas in need of improvement and implement steps intent on positive change.

Milestones during 2008 included:

- Review of HEDIS scores resulted in the implementation of a colaborative performance improvement project in which CMFHP and UniCare are introducing interventions to improve the identification and treatment of persons with Diabetes.
- Review of HEDIS scores resulted in UniCare's implementation of a pre/post-natal performance improvement project.
- CAHPS survey responses for Kansas members expressed higher satisfaction than the national and midwest comparison groups on the majority of measures.
- Utilization of Care Managers to improve service to high needs members has increased throughout the year.

- Member Care Coordination began with the physical health MCOs, CBH, the PIHP and PAHP, KHPA, and SRS to foster collegial relationships between plans and improve treatment plan development across physical and mental health spectrums. This collaborative effort will ideally result in an improved referral process among providers and plans.
- KHPA completed a thorough review of encounter data, identified data inconsistencies, and developed strategy to ameliorate the issues.
- KHPA staff conducted intensive audits of CBH, CMFHP, and UniCare to ensure contract compliance.
- HealthWave quality data has been posted to the KHPA website for public consumption.

KHPA has identified a number of important findings in this year's comprehensive review of the HealthWave program:

- The fundamental premise behind a capitated managed care program is that private health plans will respond to financial incentives by identifying opportunities to better manage the care of individuals members, improving care and lowering cost. As time has passed and HealthWave has grown, the benchmark unmanaged cost of care has become more difficult to identify, leaving KHPA without a concrete point of comparison to determine the net impact of the HealthWave program on costs. One way to measure HealthWave's impact is to identify care management activities undertaken by the plans. Through the first two years of the current HealthWave contracts, plans were able to document care management activities for approximately 0.86% of the average monthly HW 19 population and 0.40% of HW 21. Less intensive "health coaching" activities were not tracked in 2008, so the volume is unknown.
- Further assessment of the cost for the HealthWave program needs to be made to ensure appropriate return on investment. KHPA should research all combinations of alternatives to ensure the right care, at the right time, for the right cost.
- As presented in both member and provider satisfaction surveys, MCOs need to improve access to specialty providers within their respective networks. This is also a concern for HCK, Medicaid's fee-for-service network.
- Consumer survey results suggest difference in access to quality service between children and adults in HealthWave, with children faring best.
- Provider satisfaction in claims payment may present a perception of differences across health plans in other service delivery, and warrants further exploration.
- Provider satisfaction survey methodolgy needs to be improved to allow for more accurate assessment of plan differences.
- Increased coodination between state agencies and health plans is needed to increase overall participation by providers in VFC program.

Recommendations

- Explore ways in which to quantify the value of MCO services such as care management, which may include identifying methods for collecting data on services which are most often utilized and by whom. This exercise should also examine options for determining if health outcomes are affected by more intensive interventions provided through managed care.
- Shift focus toward assessing the costs and benefits that may or may not be associated with managed care and how to accurately make this determination.

- Assess current documentation and translation services ensuring they meet the needs of the Hispanic population based on the 5% increase in the Hispanic population from 2005 – 2008 for both Medicaid and CHIP (Currently 20 & 25% of the total population respectively).
- Explore ways to promote the completion of Race, Ethnicity, and Language spoken on the HealthWave application to allow for better communication with HealthWave members.
- Closely monitor Performance Improvement Projects (PIPs) and assess the level to which improvement occurs; identify and enact appropriate measures for addressing lack of improvement or progress.
- KHPA will make policy and system changes in 2010 to reduce the effects of churning, while continuing to explore opportunities to decrease temporary loss of Medicaid or CHIP eligibility.
- Explore strategies to increase the number of specialists participating in the plan networks, thereby improving specialty care availability and addressing a concern raised by beneficiaries and providers.
- Seek external support in the development of an improved survey of HealthWave and HealthConnect providers.
- Dedicate resources to the submission of reliable encounter data to support the variety of rate-setting, analytic, and quality improvement activities that depend on such data.
- KHPA should lead the effort to increase coordination among state agencies and health plans to improve the rate of PCPs participation in the Vaccine for Children program.
- KHPA should continue to monitor the Comprehensive Diabetes Care HEDIS measure to ensure improved care following the diabetes based Performance Improvement Project.
- KHPA should develop strategies to ensure the MCOs improve member satisfaction relating to wait time in the physicians office.
- KHPA should explore the gap in provider satisfaction between the CMFHP and UniCare claims payment systems, ensuring improvements to UniCare's performance where necessary, and reviewing the cost-effectiveness of each plan's process for determining appropriate payments.

Appendix A

Blended Family—Those HealthWave families that have members enrolled in both HW 19 and HW 21.

Category of Service (COS)—Identifier used to consistently group and report types of service.

Churning— Process where beneficiaries going from a managed care enrollment to FFS coverage, then back to a managed care plan, due to temporary loss of eligibility.

Consumer—A beneficiary that receives a particular medical service that generally is not included in those services covered by an MCO, and therefore, likely would be paid on a fee for service basis.

Consumer Assessment of HealthCare Provider and Systems (CAHPS)—national standardized survey of beneficiaries to determine their level of satisfaction with their health care, their providers, and the customer service affiliated with their care.

Delivery Payments—The payment made to providers after a pregnant woman has delivered her baby. Prenatal care is included in the cost of delivery, and is paid all at once, when delivery encounter data is received.

Federal Poverty Level (FPL)—Income level index used to identify eligibility in the HW 19 and HW 21 programs.

Fee-For-Service (FFS)—Coverage methodology in which a provider of service is reimbursed by Kansas directly for services rendered.

Healthcare Effectiveness Data and Information Set (HEDIS)—National standardized tool that compares the quality of care given by health plans

HealthConnect Kansas (HCK)—The Primary Care Case Management (PCCM) model of managed care in which KHPA contracts directly with primary care providers to act as "gatekeepers" by providing medical homes and referrals to specialty care for certain Medicaid members.

HealthWave 19—The portion of HealthWave comprised of members that receive Medicaid as their source of coverage. These members fall into either the Temporary Assistance to Families (TAF) or Poverty Level Eligible (PLE) aid categories.

HealthWave 21—The portion of HealthWave comprised of members that receive the State Children's Health Insurance Program (CHIP) as their source of coverage. This group is made up solely of children 18 years and younger between 101 -200% of the Federal Poverty Level.

Managed Care Organization—A company through which medical coverage is administered.

PAHP—Prepaid Ambulatory Health Plan offering mental health treatment to HW 19 members. Contract is administered by SRS.

PIHP—Prepaid Inpatient Health Plan offering substance abuse treatment to HW 19 members. Contract is administered by SRS.