Robert Moser, MD
Secretary
KanCare and Population Health

KanCare goals are consistent with KDHE focus on integrating public health and primary care.

Not just focused on a medical model, but an integrated approach that uses:
• A system of resources to support members; and
• Data and information to improve the program and individual interventions
In 2014, pay for performance measures shift from operational to outcomes:

- Physical health
- Behavioral health
- HCBS/long-term care
- Nursing facilities
Outcomes Reporting Timeline

- Physical health measure data collected after first quarter of each subsequent year (2013 complete after March 2014)
  - Reported to NCQA by June, with cumulative national results (establishing percentiles) released by NCQA in July
- Spring CAHPS survey results expected July-August
- Behavioral health survey results available in fall
- NOMs measured quarterly
- HCBS waiver performance measures measured quarterly, reported annually per 1915(c) waiver
- New state-developed measures (increased employment, etc.), generally reported 60 days after each quarter
Recurring Cycle

Services delivered during calendar year (Baseline set when applicable; results based on targets thereafter)

Medical record (results) data collected/analyzed May-June

Results reported to NCQA; cumulative national results reported - preliminary in July; comparative percentiles in Oct.

Administrative (claims) data collected/analyzed March-April

(For some measures - HCBS, Behavioral Health or state developed - this recurs quarterly)

Member surveys (CAHPS for sample of all and mental health for sample of those members) start in Spring; collected Summer; results late Fall.
Using Data

Data, both in aggregate and at the individual level, drive program improvement and interventions.

Example: Performance Improvement Projects

Collaborative PIP (all three MCOs): Comprehensive Diabetes Management
Using Data, cont.

Individual MCO PIPs – results monitored quarterly:

• Amerigroup: Well Child Checks for ages 3-5
• Sunflower: Initiation and Engagement for Substance Use Disorder Services
• United: Access to Community Services Following Hospitalization for Mental Health Treatment

Using data to connect chronically ill with providers:
Health Homes
Susan Mosier, MD
Director of Medicaid Services
Health Homes

- The term “health home” is unique to Medicaid
- Health homes are an option which states can choose to provide within their Medicaid programs
- A health home is not a building, but is a comprehensive and intense system of care coordination
- Health homes do not replace acute care services
Federal Parameters

Must be eligible for Medicaid, and have at least:

- Two chronic conditions;
- One chronic condition and is at risk for another chronic condition; or
- One serious and persistent mental illness
Chronic conditions

- Mental health conditions
- Substance use disorder
- Asthma
- Diabetes
- Heart disease
- Being overweight
- Expanded list
Six Core Services

• Comprehensive care management
• Care coordination
• Health promotion
• Comprehensive transitional care
• Individual and family support
• Referral to community and social support services, if relevant
Role of HIT

- To link services
- Quality reporting
- Provider supports/requirements
- Facilitate communication and feedback
Other States

• To receive federal funding for health homes, states must amend their State Medicaid Plans
• 12 states currently operate Medicaid health homes programs
• 3 states operate them using two State Plan amendments (SPAs)
• Remaining states have a single SPA
Three Approaches to Integrated Care

• Facilitated referral - develop formal and informal relationships
• Co-locate - behavioral health clinician in a physical health setting or vice versa
• In-house - provision of primary care and behavioral health care together
KanCare Health Home Model

MCO staff + health home partner = a Health Home

Medicaid Agency

MCO

MCO

MCO

CIL

CMHC

PCP

Safety Net Clinic

SUD

CDDO

Other

Recipient

Recipient

Recipient

Recipient

Recipient

Recipient

Recipient
Service Structure

- Individual and Family Supports
  - Health Promotion
  - Care Coordination
  - Referral to community and social supports
  - MCO

- Member with designated condition
- Comprehensive transitional care

- HH Partner (HHP)
- Comprehensive care management
Improving Health

• Critical information is shared
• Patient has tools needed to help manage his/her chronic condition
• Necessary screenings and tests occur timely
• Unnecessary emergency room visits and hospital stays are avoided
• Community and social supports are in place
Health Home Goals

• Reduce utilization associated with avoidable (preventable) inpatient stays
• Improve management of chronic conditions
• Improve care coordination
• Improve transitions of care between primary care providers and inpatient facilities
Target Populations

• First target population is people with serious mental illness (SMI)
• Second target population includes people with asthma or diabetes who are also at risk for another chronic condition
• Can’t exclude dual eligibles or limit to a particular age group
• All HH members must be in KanCare and must select a HHP within the MCO network
Enrollment

• Passive enrollment with “opt out” feature
• Enrollee will receive a letter; may choose to opt out
• Must have a choice of health home provider, but may be limited to certain number of times in a year
• Grievance and appeal rights
Meet Earleen

Earleen is 41 years old
Earleen has bipolar disorder
Earleen has COPD
Earleen has diabetes
Earleen has been admitted to the hospital 4 times in the past year.
Earleen is unemployed but interested in employment
KANCARE Health Home: Scenario – How will KanCare help Earleen?

**MCO**
- Care Management
  - Assists in locating primary care physician and schedules initial appointment and follow-up appointment
  - Assists in scheduling appointments with specialists and physical therapist
  - Communicates and collaborates with PCP, Specialists, and Care Coordinator
  - Assists in setting up NEMT
  - Refers for diabetes education

**CMHC**
- Case Coordinator
  - Works with Earleen to help her ask her PCP and specialists questions, and to understand information provided
  - Refers Earleen to CMHC Psychiatrist and private therapist
  - Helps Earleen understand medications and diabetes education information
  - Connects Earleen and her family to support group for people with bipolar and other conditions
  - Assist Earleen to complete a subsidized housing application
  - Refers Earleen to Vocational Rehabilitation

**Communication between Care Coordinator and Case Management**

**Earleen**

**HIT**
KANCARE Health Home: Scenario – Meet Bobby

- Bobby has Asthma
- Bobby is 8 years old
- Bobby’s Asthma is not controlled
- Bobby is in Foster Care and has moved to several different families in the past several years
- Bobby has gone to the ER several times this year for Asthma related issues
- Bobby possibly has Fetal Alcohol Syndrome
KanCare Health Home: Scenario – How will KanCare help Bobby?

**MCO**
- Care Coordination
- Arrange for environmental assessment to remove Asthma triggers
- Provide information to foster parents about proper use of Asthma controller and rescue medications
- Set up family and Bobby with support group for child with complex conditions
- Assist in transition from one foster home to another

**Communication between Care Coordinator and Case Management**

**Pediatrician**
- Makes sure the foster family understands condition
- Referral to determine if Bobby has Fetal Alcohol Syndrome
- Make sure Bobby has all immunizations and that he has regular check ups
- Develop an Asthma action plan that can move with Bobby when he moves to a different foster family and for school nurse
- Medication monitoring and management

**Bobby**
Payment Structure

State pays MCO for each HH member

MCO shares HH payment with HH Partner (HHP) through contractual arrangement, taking into account the division of 6 HH core services

MCO and HHP jointly provide HH core services as specified in their contract

MCO pays for all KanCare services

KanCare Member

Physician

Specialist

Safety Net Clinic

Behavioral Health Services

Home and Community Based Services

HH Partner may be one of these; providers will still provide other services beyond HH
Health Homes Project Structure

• Interagency team of KDHE and KDADS staff
• Technical assistance partner – Center for Health Care Strategies (CHCS)
• Project team of state staff, university and actuary partners, with MCO representatives
• Health Homes Focus Group – 80+ stakeholders who provide advice and input
Where We Are

- Engaging stakeholders
- First SPA drafted
- SAMHSA consultation on first SPA complete
- Monthly calls with CMS
- Working on operational issues
- Preparing second SPA
- Implement HHs for two target populations (SMI and chronic conditions) July 1, 2014
Staying Informed

• Web page:  www.kancare.ks.gov/health_home
• Monthly newsletter: *Health Homes Herald*
• E-mail questions/comments:  healthhomes@kdheks.gov
Kari Bruffett
Director, KDHE-DHCF
Eligibility

Total Medicaid/CHIP:

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<th>Month</th>
<th>Medicaid</th>
<th>CHIP</th>
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<td>December</td>
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Applications by Month:

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<th>Month</th>
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<th>Members Eligible for CHIP</th>
<th>Members Ineligible</th>
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</tbody>
</table>
Trend in Applications

Federal Marketplace “flat file” has 7,725 records of individuals assessed as likely eligible for Medicaid/CHIP. (As of flat file received 1/14)

The flat file does not contain enough information to make eligibility determinations.

KDHE has contacted all individuals for whom contact information is complete in the flat file.
Expect outreach to those individuals will lead to a bump in applications through the KEES online self-service portal.

Last week, 1,300 online applications were submitted to the portal, compared to an average of 635 each week in October/November/December.
Open Enrollment

Members who joined KanCare in January 2013 can change plans during the open enrollment period (12/1/13 to 3/2/14). Approximately 330,000 individuals received packets.

As of 1/14:
- 7,155 changed plans effective 1/1
- 876 changed plans effective 2/1

Members who gained eligibility after 1/1/13 will have open enrollments corresponding with their initial enrollment date.
Executive Summary

Please see Executive Summary, which includes:
• Capitation Payments
• Members by Cohort
• Network Count
• Claims At a Glance
• Denials
• Value-Added Services
• “In Lieu of” Services
• Grievances and Appeals
• Plan of Care Reductions
• Pay for Performance Measures