Chapter 12: HealthConnect Kansas

Executive Summary

Overview

HealthConnect Kansas (HCK) is a statewide primary care case management program established in 1994 to provide Medicaid beneficiaries with access to quality medical care in an efficient and economical manner. The Kansas Health Policy Authority (KHPA) contracts directly with Primary Care Case Managers (PCCMs) who receive a per member per month (PMPM) fee to provide some components of a medical home. They also act as "gatekeepers" for specialty care referral. Medical services obtained by HCK members are reimbursed on a fee-for-service (FFS) basis. Some of these expenditures are broken down in service-specific Medicaid program reviews (such as the Aged and Disabled program review). This review focuses on aggregate medical service expenditures for the population served in HCK, and the specific role of care management implied by the PCCM model.

Key Points

- In January 2007 approximately 50,000 beneficiaries were transferred from the HealthConnect (HCK) program into our expanded HealthWave capitated managed care program. These beneficiaries were the generally healthy low income mothers and/or children and they resided in the eastern two-thirds of the state (Regions 1 and 2). Because of the large transfer of beneficiaries to HealthWave, the HCK program has been transformed into to a much smaller program focused primarily on providing primary care for Social Security Income (SSI) and MediKan disabled beneficiaries. The population remaining in HCK experiences a high prevalence of chronic disease, including diabetes, heart disease and mental illness. Costs for conditions such as heart disease and diabetes are expected to rise in relative importance within HCK, and in the management of Medicaid's medical services as a whole.

- Through the direction of the department of Social and Rehabilitation Services (SRS), and in response to concerns raised by Centers for Medicare and Medicaid Services (CMS) over funding of the previous system, mental health care funding and management was also restructured, resulting in the transfer from the HCK fee-for-service program into the Prepaid Ambulatory Health Plan (PAHP), a separately-operated mental health managed care program in July 2008. The purpose of the PAHP is to increase beneficiaries access to mental health providers that are willing to meet specified mental health treatment needs.

- Participation of primary care providers in the HCK program remains strong, and the program receives relatively positive ratings by participating providers.

- This program review confirms a strong overall level of access to primary care providers within

HCK, but there is limited evidence of the impact of the PCCM program on beneficiary health care and health outcomes. The PCCM program was initiated to increase access to primary care, but other aspects of the medical home have not yet been applied within HCK, leaving many of KHPA's highest-cost, highest-need beneficiaries without a coordinated and cost-effective system of care.

- Many HCK beneficiaries report high satisfaction with care received, and a relatively high level of access to care. Lower scores were observed for some of the core outcomes associated with a medical home, such as timeliness of care and effective physician-patient communication.

Recommendations

The HCK program has experienced dramatic changes in both covered populations and services during FY 2007 and FY 2008. The KHPA does not recommend further changes in the HCK program in FY 2009 and FY 2010. However, recommendations from other program reviews may have a direct bearing on the HCK program and its population, and could lead to further transformation of the program in future years:

- An increased focus on the chronic medical conditions of those remaining in HCK is important as the KHPA seeks to improve the delivery of cost-effective care. An emphasis on cost effective care is reflected in the other Medicaid program reviews that directly affect the HCK program such as hospital, pharmacy, home health services and the application of a medical home for the aged and disabled.

- A KHPA quality improvement plan, also addressed in a separate program review, is being implemented in FY 2009 that will create performance and outcomes information which will allow for comparison across health plans, including HealthWave and HealthConnect.

In addition to these Medicaid initiatives, KHPA is part of a large stakeholder process engaged in a comprehensive effort to promote the medical home concept statewide. These efforts will ultimately include payment reforms for specific components of care, for example, increased payment to providers who offer flexible hours of operation, or who use electronic health records. The target outcome in these efforts is an improvement in the quality of care, health outcomes, and long-term medical costs which are expected to decline with a structured, systematic approach to primary care.

Overview and Background

HealthConnect Kansas (HCK) is a statewide primary care case management program established in 1994 to provide Medicaid beneficiaries with access to quality medical care in an efficient and economical manner. The Kansas Health Policy Authority (KHPA) contracts directly with Primary Care Case Managers (PCCMs) who receive a per-member-per month (PMPM) fee to provide some components of a medical home. They also act as "gatekeepers" for specialty care referral. HCK PCCM assignments and referrals are administered by Kansas Medicaid's fiscal agent, Electronic Data Systems (EDS). Medical services obtained by HCK members are reimbursed on a fee-for-service (FFS) basis. These expenditures are included in other FFS specific program reviews. This review focuses on aggregate medical service expenditures for the population served in HCK, which changed dramatically with the expansion of the HealthWave in January 2007.

The PCCM

The PCCM agrees to provide medical care to a select group of Medicaid members, or when necessary, refer the beneficiary to another provider. The primary care case manager is paid a $2 monthly fee for each beneficiary assigned to their management, plus the Medicaid fee-for-service rate for medical services. Beneficiaries are restricted to their assigned primary care case manager and may not receive medical services from other providers without the case manager's approval. The two exceptions are emergency services provided in a hospital emergency room and those services exempt from case management referral, such as obstetrical care or family planning. Each HCK primary care case manager may contract to accept and provide services for a minimum of 10 and up to a maximum of 1,800 beneficiaries.

The following provider types are allowed to act as a PCCM within the HCK program:

- Advanced Registered Nurse Practitioners (ARNP)
- Family Practice Physicians
- Federally Qualified Health Centers (FQHC)
- General Practice Physicians
- Indian Health Centers (IHC)
- Physician Assistants (PA)
- Internal Medicine Physicians
- Local Health Departments (LHD)
- Obstetrics/ Gynecology Physicians
- Pediatric Physicians
- Rural Health Clinics (RHC)
- Group practices of the provider types specified

Participation in HealthConnect

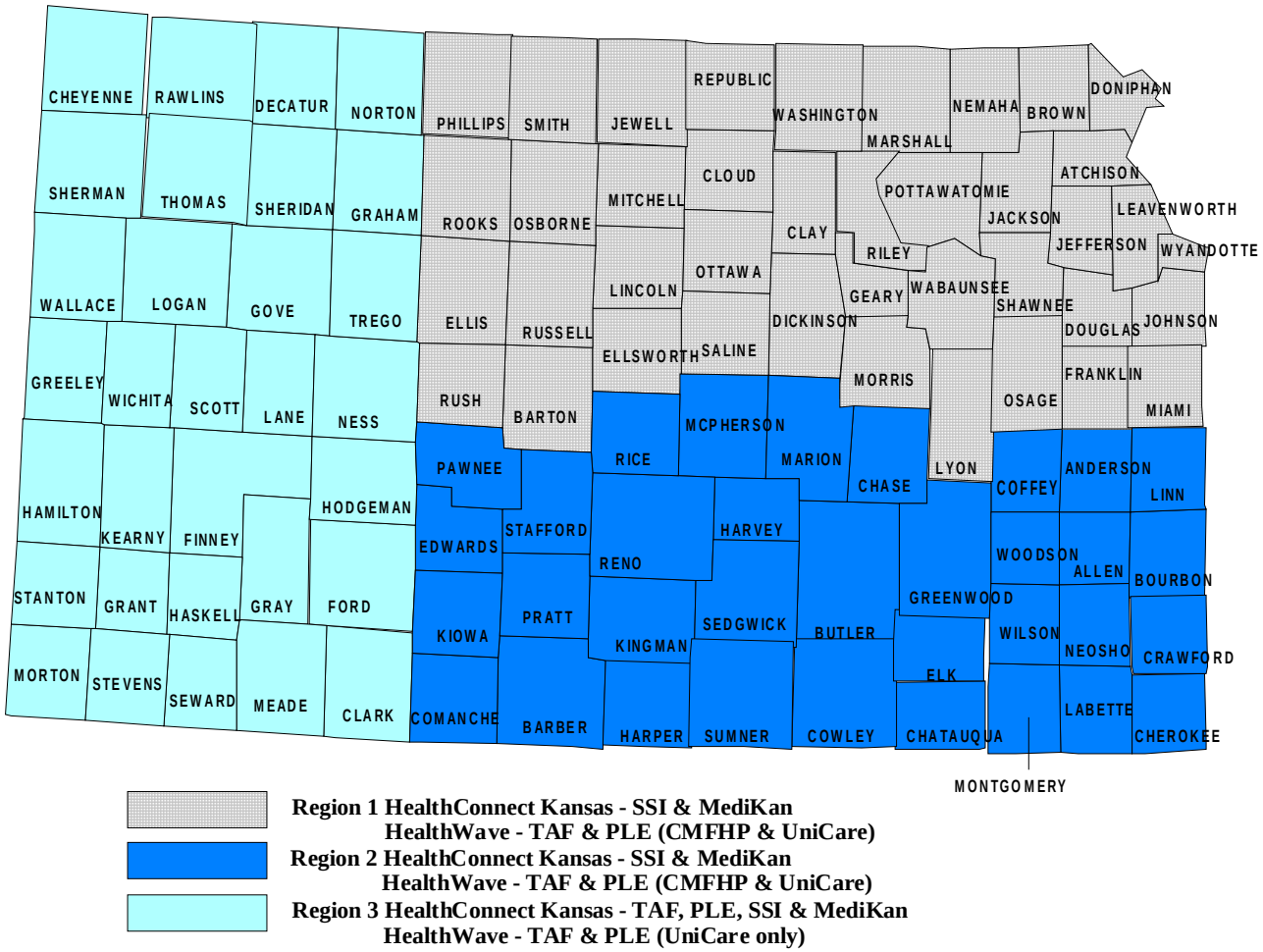
HealthConnect Kansas provides a broad array of services to beneficiaries with vastly different health care needs. Populations who receive HCK services qualify for Medicaid based on one or more of the following eligibility categories:

- Supplemental Security Income (SSI), a cash payment program administered by the Social Security Administration that pays benefits to aged and disabled individuals with low income and assets.
- MediKan, also known as General Assistance, provides coverage for individuals who have a severe condition that has not been determined to meet Social Security Administration (SSA) criteria. MediKan recipients also receive General Assistance cash benefits from SRS.
- Temporary Assistance to Families (TAF) Families with children under 30% of federal poverty level.
- Poverty Level Eligible (PLE) Pregnant women and children with family income below 150% of federal poverty level.

In January 2007, approximately 50,000 HCK beneficiaries in Regions 1 and 2 (defined in Graph 1) were transitioned into the HealthWave program and given a choice of enrolling in either Children's Mercy Family Health Partners (CMFHP) or UniCare Health Plan of Kansas (UniCare). This transition was meant to provide improved access to quality health care by leveraging a competi-

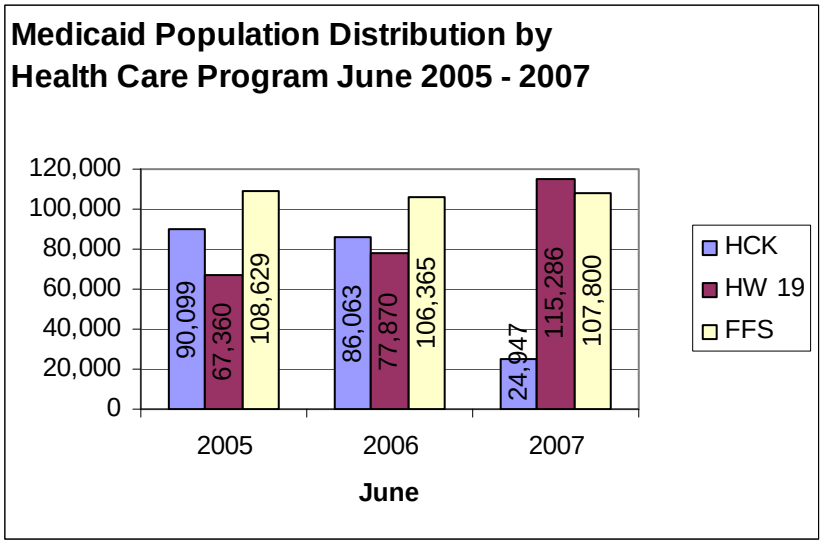
tive environment. The Managed Care Organizations (MCO's) that participate in HealthWave offer case management services, educational opportunities and a more robust set of core services. In these regions HCK is made up of SSI and MediKan beneficiaries. Region 3, which is in western Kansas, has fewer beneficiaries and providers. There is only one HealthWave MCO available (UniCare); TAF and PLE beneficiaries are given a choice between HCK and UniCare, while SSI and MediKan beneficiaries are assigned to HCK (see Graph 1).

Graph 1



The expansion of HealthWave in Regions 1 and 2 is demonstrated below in Figure 1 with an increase in the HealthWave population from June 2005 – 2007 (labeled HW 19). Also shown in Figure 1 are the impacts of new federal eligibility requirements for the Medicaid program. Between June 2006 and June 2007, the HCK and HealthWave population declined by about 20,000 persons due to the implementation of new federal citizenship and identity documentation requirements (which took effect July 2006). Implementation of these new eligibility requirements, coupled with the expansion of HealthWave, explains why the HCK population dropped by about 60,000 even though the number of Medicaid beneficiaries enrolled in HealthWave grew by only about 40,000 enrollees.

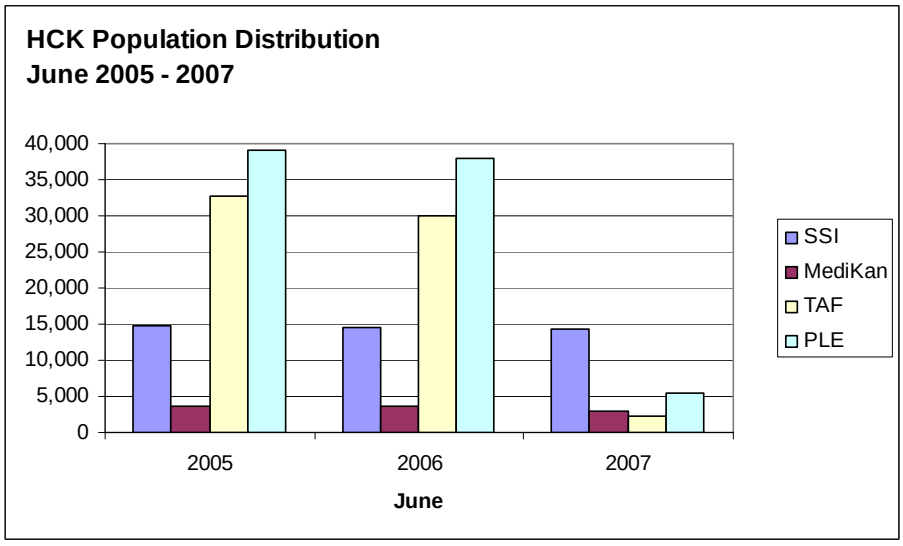
Figure 1



Given the transition of 50,000 HCK members in Regions 1 and 2 into the HealthWave program, the majority of the remaining beneficiaries in the HCK in June 2007 had SSI or MediKan coverage (referenced in Figure 2 below).

Also evident is a decline in the HCK and MediKan population, which coincides with the implementation of the new Presumptive Medical Disability (PMD) program, which was implemented in 2006. The PMD program screens MediKan applicants for probable eligibility for federal disability benefits and immediately enrolls in Medicaid those who are likely to qualify for full disability. This allows the state to draw down additional federal funds to provide services to this population and allows those who qualify for Medicaid to have a broader set of benefits (Medikan benefits are more limited). As expected, enrollment in MediKan declined by over a thousand following the implementation of Presumptive Medical Disability. Total SSI enrollment, including both the fee-for-service and HCK participants, grew by 4.22% in FY 2007, partly as a result of the enrollees added through the PMD process.

Figure 2



In Kansas, certain beneficiaries are not required to be assigned to a managed care program but are allowed to "Opt-In" if they would like to participate in managed care. Those who do not opt-in are enrolled in the FFS program. Members who default to the FFS program in this fashion, but who are allowed to opt-in to either HCK or HealthWave, are: Children with Special Health Care Needs (CSHCN); members with SSI that are less than 21 years of age; and Native Americans. Members are also allowed to opt-out of managed care at a later date. Table 1 presents a snapshot of the enrollment choices of the total opt-in population in June of each year, 2005-2007, revealing a decline in the percentage selecting managed care.

Table 1

Opt-in Status in June 2005-2007	CSHCN	SSI <21	Native Americans	Total	% of Eligibles Who Opt-in
2005 HCK Opt-ins	27	3,506	930	4,463	
2005 HW Opt-ins	25	0	807	832	
2005 Total Opt-ins	52	3,506	1,737	5,295	
2005 Total Opt-In Eligibles	59	5,469	3193	8,721	60.7%
2006 HCK Opt-ins	36	3,499	833	4,368	
2006 HW Opt-ins	26	0	945	971	
2006 Total Opt-ins	62	3,499	1,778	5,339	
2006 Total Opt-In Eligibles	71	5,805	3,320	9,196	58.1%
2007 HCK Opt-ins	11	3,533	480	4,024	
2007 HW Opt-ins	20	0	670	690	
2007 Total Opt-ins	31	3,533	1,150	4,714	
2007 Total Opt-In Eligibles	36	5,810	3,305	9,151	51.5%

Though it appears there are fewer opt-in beneficiaries who choose managed care, this decline is somewhat artificial. Prior to November 2003 these groups were mandated into either HCK or HealthWave. When the current Medicaid Management System (MMIS) was implemented in 2003, new logic was developed to allow these subgroups to opt-in to managed care rather than being automatically assigned to managed care. However, if a member was already assigned to managed care in 2003 that assignment was not changed. Over time, with normal turnover in the opt-in population, the number in managed care has declined as fewer new members voluntarily select managed care than were automatically enrolled before 2003. This suggests that the HCK-eligible population is not convinced of the value of the primary care case manager (PCCM) model of care available in HCK. This information may help inform the broader effort to identify opportunities to enhance and re-think the implementation of a medical home in the Medicaid program.

Demographics in HealthConnect Kansas

This section examines the HCK population in more detail. As described above, there was a dramatic decline in HCK participation due to two main factors: the implementation of federal citizenship and identity requirements in July 2006, which made it more difficult for people to enroll in Medicaid, and second the expansion of HealthWave in January 2007. Despite this decline, there appear to be only modest changes in the percentage distribution of the HCK population by age,

gender or race/ethnicity (see Figure 3, Figure 4 and Table 2). These distributions are based on total enrollment during each full fiscal year. The FY 2007 data includes six months of enrollees before the expansion of HealthWave in January 2007 and six months afterwards. The full impact of the reduction in the HCK population on the distribution of enrollees by age, gender and race/ethnicity may not be fully evident until FY 2008, the first complete year under the newly expanded HealthWave program.

Figure 3

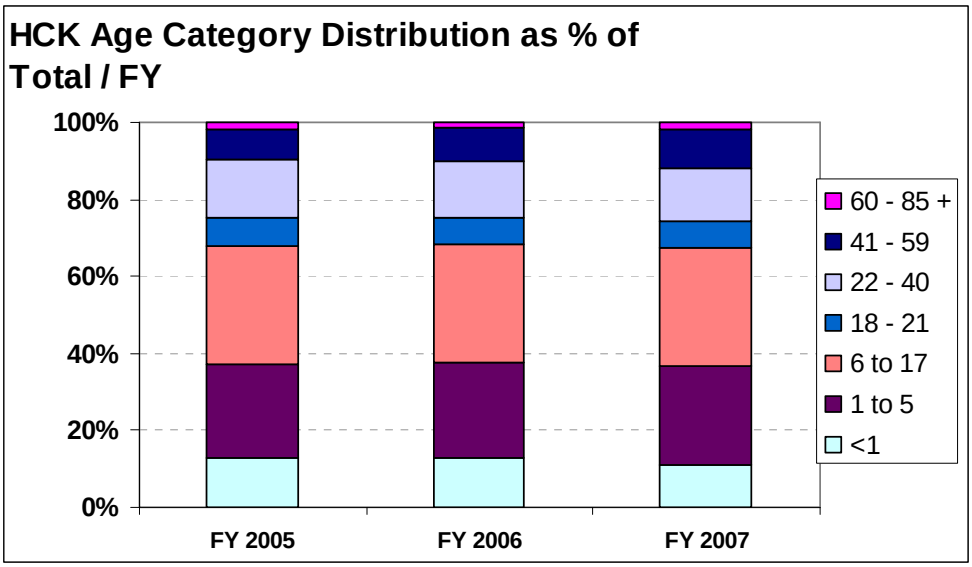


Figure 4

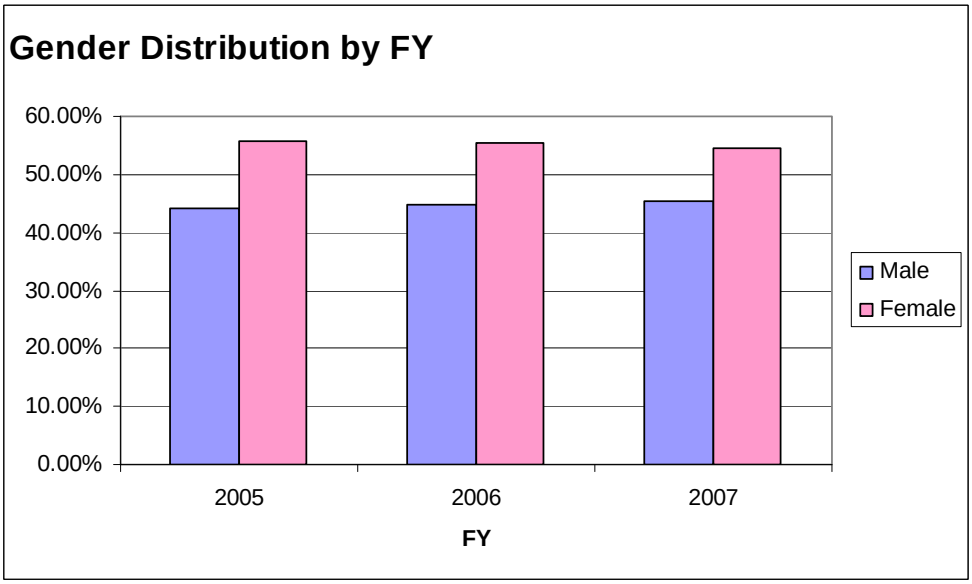


Table 2
Race Distribution by FY

Race	FY 2005	FY 2006	FY 2007
American Indian/Alaska Native	.97%	.89%	1.77%
Black or African	16.66%	16.28%	14.09%
Unknown	4.14%	4.19%	2.91%
Pacific Islander/Hawaii Native	.06%	.08%	.01%
Asian	1.51%	1.58%	1.80%
White	75.29%	75.48%	74.10%

Service Utilization and Expenditures

HCK program expenditures, including the $2 per-member/per-month (pm/pm) case management and fee-for-service claims, are displayed below. There was a reduction in both the TAF and PLE population and total expenditures for these populations in SFY 2007 (see Figure 3 above and Figure 5 below). This reduction directly relates to the transition of the 50,000 beneficiaries from HCK to HealthWave in January 2007. Temporary Assistance to Families (TAF) and Poverty Level Eligible (PLE) also experienced a reduction in average monthly expenditure, which would appear to indicate that average costs for members transferred to HealthWave are lower than costs for those remaining. This implies lower average utilization by TAF and PLE beneficiaries residing in Region 3 in FY 2007 as compared to utilization by beneficiaries residing primarily in Regions 1 and 2 in FY 2006 (Figure 6). The reason for this difference in utilization and spending per person remains unexplained. SSI and MediKan had slight reductions in population size, while experiencing increases in expenditures as well as average yearly cost.

As noted above, the drop in enrollment of the MediKan population (see Figure 1) is the result of the ongoing transition of disabled applicants to the Presumptive Medical Disability (PMD) program. The residual population appears to have higher overall costs as indicated by the rise in per person spending between SFY 2006 and 2007 (see Figure 6). Data below suggests the increase in spending by MediKan members was concentrated in mental health services (see Figure 7 and 12.) Note that services available to MediKan members are tailored and do not include the full Medicaid service package. MediKan provides limited benefits to adults whose applications for federal disability are being reviewed by the Social Security Administration. Health benefits include the provision of medical care in acute situations and during catastrophic illness. Many inpatient hospital services are excluded from MediKan coverage, which may further concentrate observed health care costs among mental health conditions.

Figure 5

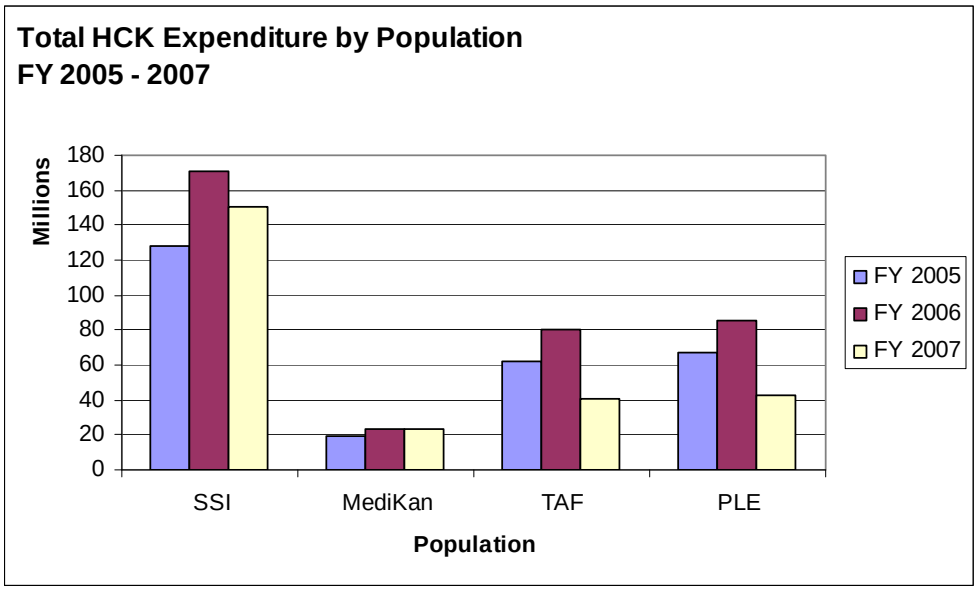
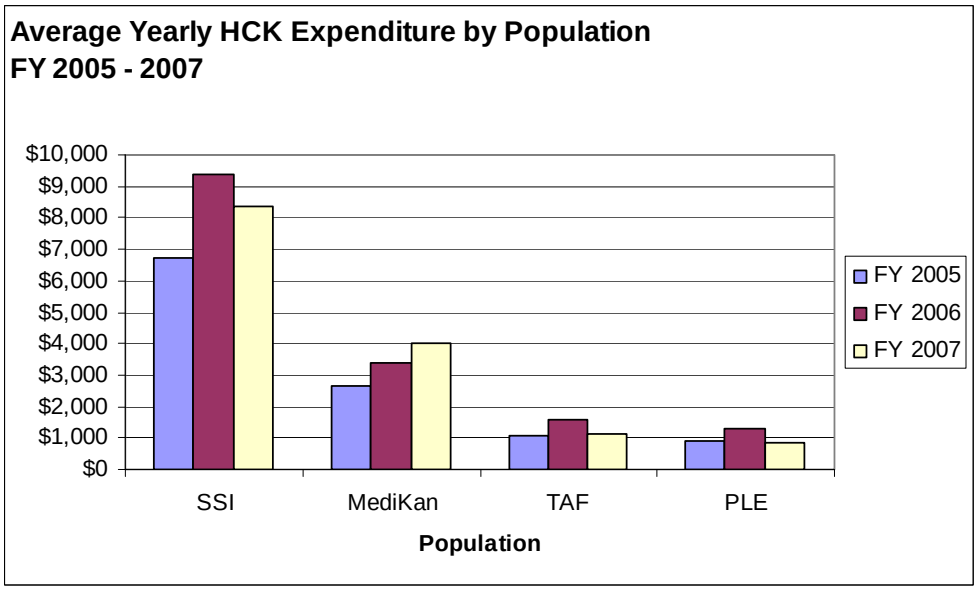


Figure 6



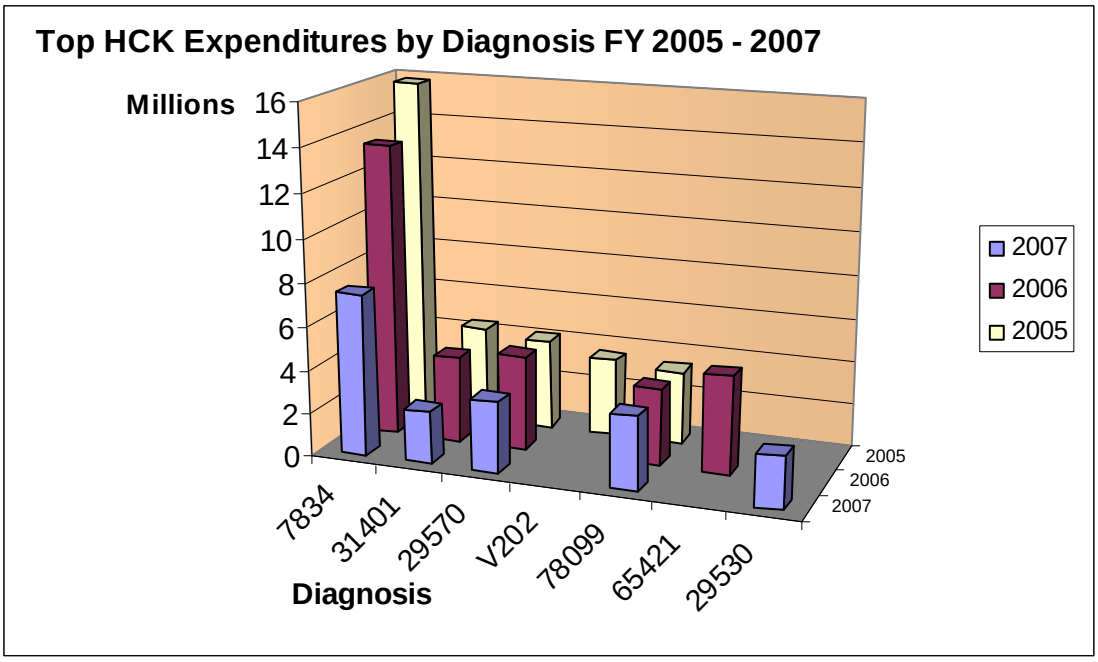
Spending by Diagnoses

The largest fraction of services provided to HCK members fell under the procedure code "lack of physiological development", followed by procedure codes for various mental health diagnoses. The use of the diagnosis "lack of expected physiological development" was greatly reduced from SFY 2005 – 2007 as providers have more accurately diagnosed members instead of utilizing this non -specific code. Figure 7 illustrates the distribution and expenditure of the top diagnoses for SFY 2006 – 2007. Large reductions in spending are evident in SFY 2007, coinciding with the January 2007 exit of most TAF and PLE enrollees to the expanded HealthWave program.

The highest cost diagnoses in FY 2005 and FY 2006 reflect a younger and healthier HCK population and include attention deficit disorder, routine care for children, and Caesarean deliveries. With

the exit of most parents and children from HCK mid-way through FY 2007, these diagnoses fell in rank and were replaced by care for mental health indications such as schizoaffective disorder and paranoid schizophrenia.

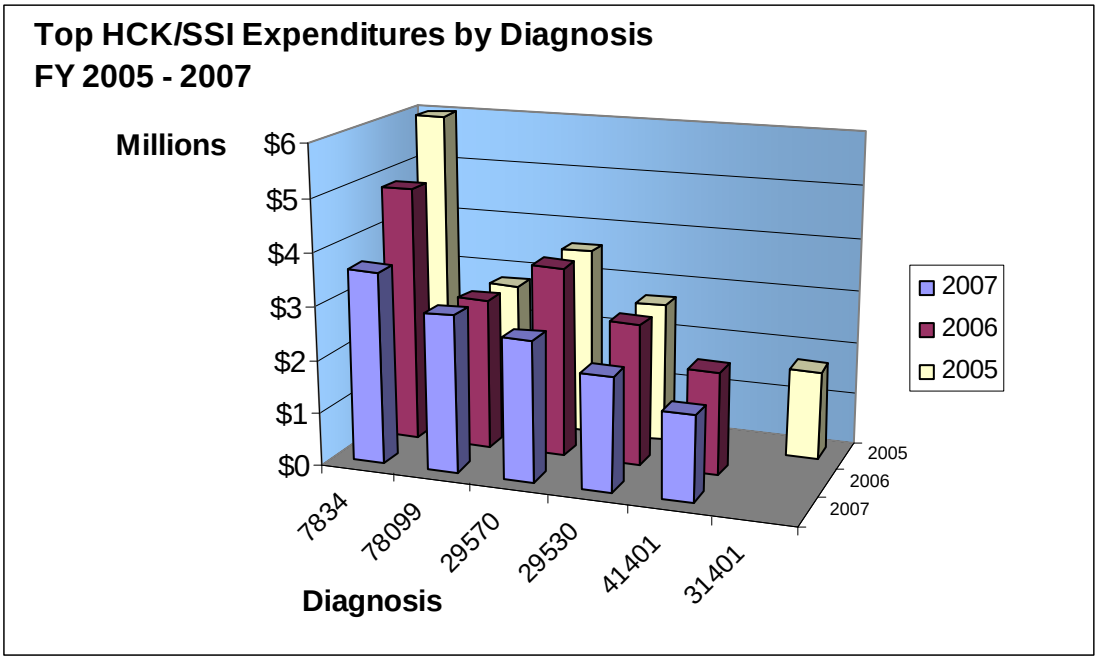
Figure 7



- 7834 Lack of expected normal physiological development
- 31401 Attention deficit disorder of childhood with hyperactivity
- 29570 Schizoaffective Disorder, unspecified
- V202 Routine infant or child health check
- 78099 Other general symptoms
- 65421 Previous cesarean delivery, delivered, w/wo mention of ante partum condition
- 29530 Paranoid schizophrenia, unspecified condition

To gain a better understanding of the nature of the HCK program going forward, Figures 8 and 9 isolate trends in spending by diagnoses for the two predominant populations that remain in HCK: SSI and MediKan. Spending patterns across these top diagnoses appear to be similar across years, although with a steady increase in rank for the non-specific procedure code "other general symptoms." Also evident is a general trend towards less common diagnoses such as, a reduction in the concentration of spending among these top diagnoses. The analysis presented above demonstrates rising spending in the Supplemental Security Income (SSI) category, and yet spending within these top diagnoses appears to be falling somewhat. This suggests that spending is more evenly spread across a greater number of diagnoses in later years. It is not known whether this indicates changes in the population's health status and health care needs, or whether it may reflect a change in the composition of SSI participants in HCK.

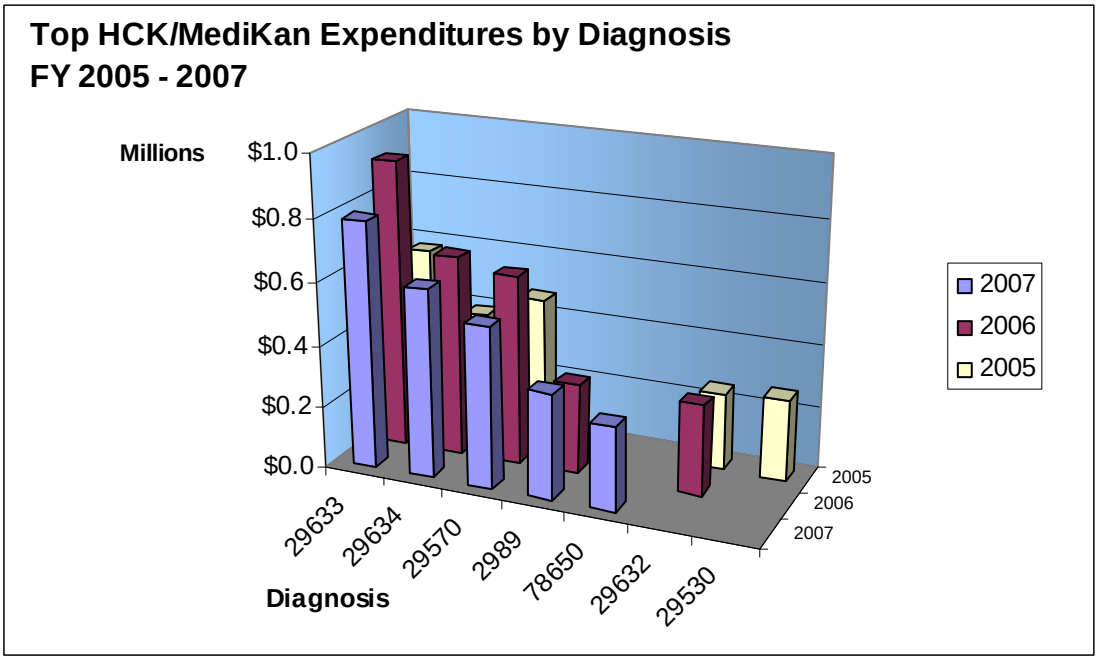
Figure 8



- 7834 Lack of expected normal physiological development
- 78099 Other general symptoms
- 29570 Schizoaffective disorder, unspecified
- 29530 Paranoid schizophrenia, unspecified condition
- 41401 Coronary atherosclerosis of native coronary artery
- 31401 Attention Deficit Disorder of childhood with hyperactivity

Analysis of spending by diagnoses among the MediKan population suggests continuity across years in the concentration of spending among mental health conditions, although the rank importance of specific diagnoses does change over the three year period. The transition of MediKan membership into the PMD Medicaid program beginning in FY 2007, is likely to have a growing impact on the health needs of those remaining in the program, and could lead to an increasing concentration of spending among those with a mental health diagnosis. The implementation of the Prepaid Ambulatory Health Plan (PAHP) for mental health services in FY 2008 will have a large impact on the focus of the HCK program, especially for the MediKan population: most of the mental health spending within HCK were shifted into the PAHP on July 1, 2007, with the significant exception of prescription drugs.

Figure 9

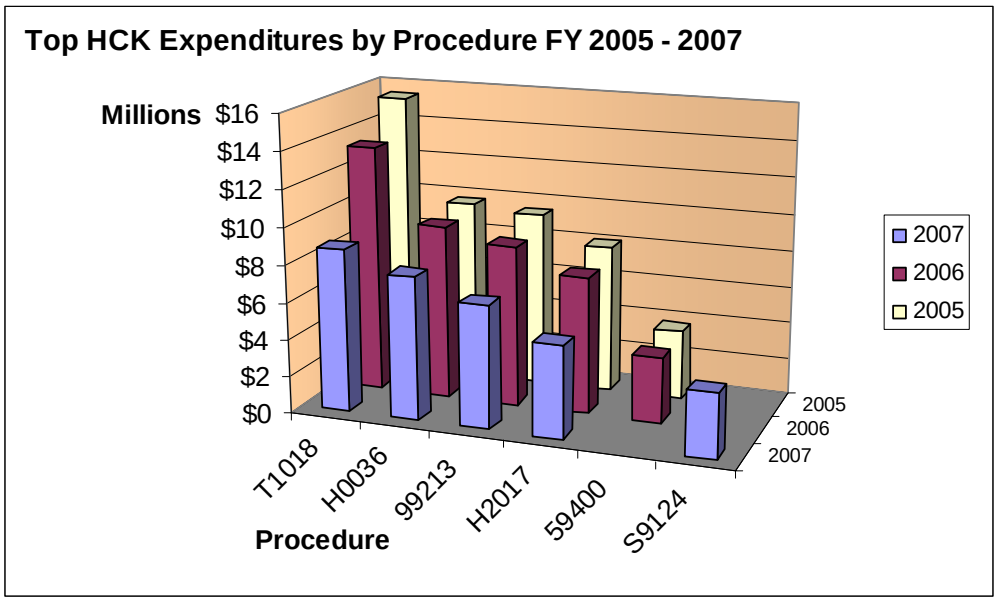


- 29633 Major depressive disorder, recurrent episode, severe, without mention of psychotic behavior
- 29634 Major depressive disorder, recurrent episode, severe, without mention of psychotic behavior
- 29570 Schizoaffective disorder, unspecified
- 2989 Unspecified psychosis
- 78650 Unspecified chest pain
- 29632 Major depressive disorder, recurrent episode, moderate
- 29530 Paranoid schizophrenia, unspecified condition

Spending by Procedure

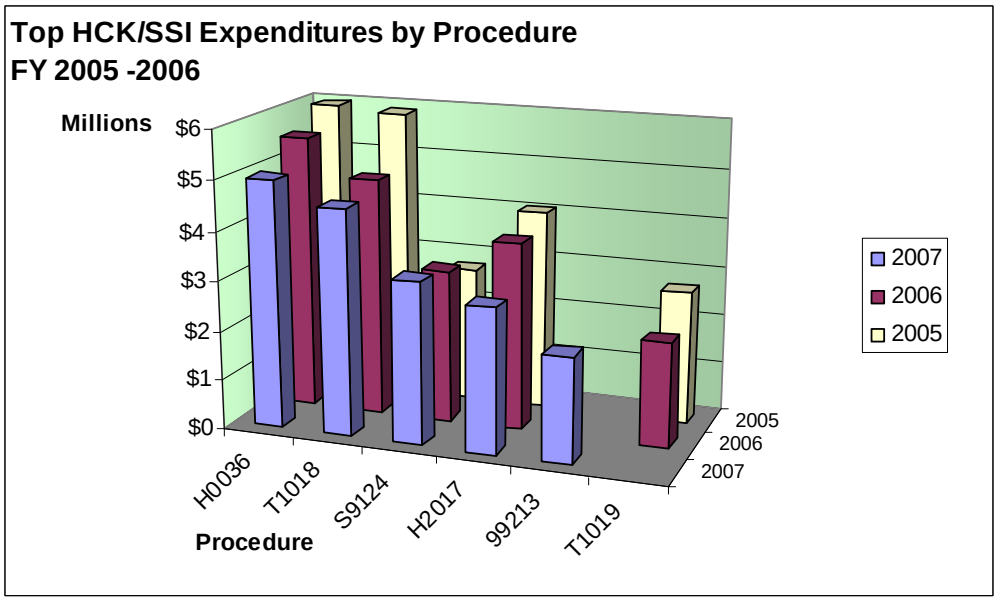
Examination of HCK expenditures by the highest-reimbursed procedure codes provides data on on the largest cost-drivers for the different populations within HCK. Figure 10 suggests the two primary populations remaining in HCK have very different needs and utilization patterns (SSI and Medikan beneficiaries). The number one individual procedure is school-based services. These services consist of Medicaid-reimbursable expenses provided in a school setting to Medicaid-eligible children. Children with disabilities receive significant therapies in a school setting that qualify for Medicaid reimbursement. Figures 11 and 12 reveal a strikingly different set of services provided to these two groups, with a heavy concentration of spending for mental health procedures within the MediKan population. Spending on mental health by the MediKan population is expected to change significantly in FY 2008 with the implementation of the PAHP for mental health care. This change will shift expenditures from a fee-for-service (FFS) basis to a capitated rate. The PAHP (Prepaid Ambulatory Health Plan) contract is overseen and evaluated by SRS, and will be the subject of a targeted program review in the 2009 Medicaid transformation process.

Figure 10



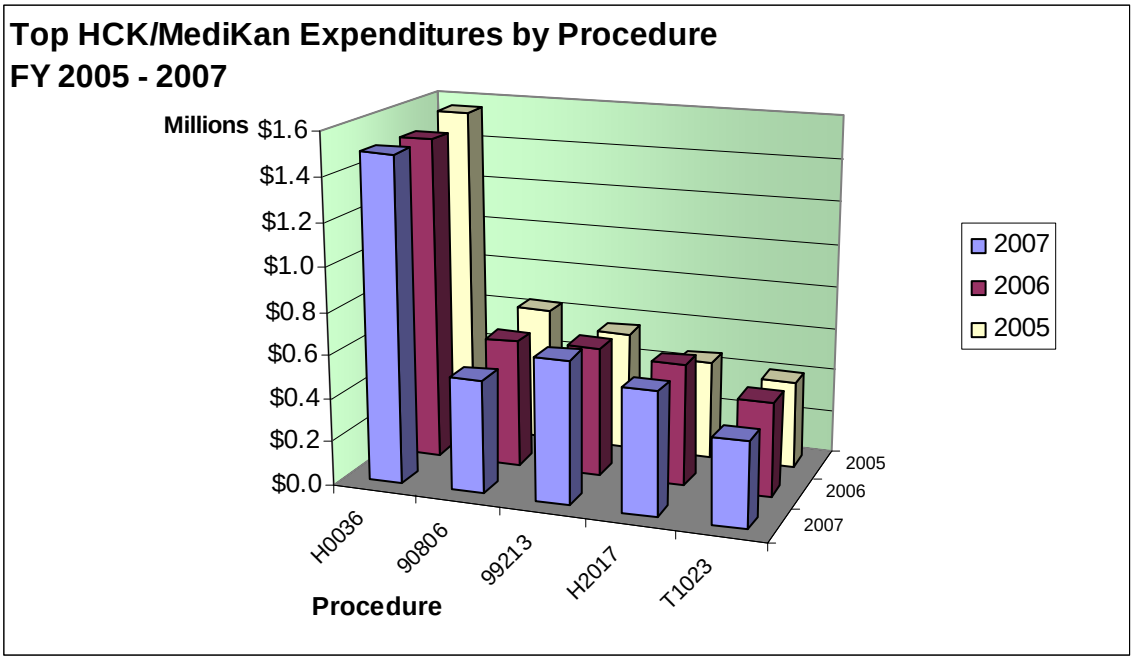
- T1018 School-Based Individualized Education Program Services (IEP)
- H0036 Community Psychiatric Supportive Treatment, face-to-face, per 15 minutes
- 99213 Office or other outpatient visit for the eval/management of established patient
- H2017 Psychosocial Rehabilitation Services, per 15 minutes
- 59400 Routine Obstetric care including ante partum, vaginal delivery
- S9124 Nursing Care, in the home, by LPN per hour

Figure 11



- H0036 Community psychiatric supportive treatment
- T1018 School-based individualized education
- S9124 Nursing care, in the home
- H2017 Psychosocial rehab service, per 15 minutes
- 99213 Office or other outpatient visit
- T1019 Personal care services, per 15 minutes

Figure 12



- H0036 Community psychiatric supportive treatment
- 90806 Individual psychotherapy, insight oriented
- 99213 Office or other outpatient visit
- H2017 Psychosocial rehab service, per 15 minutes
- T1023 Targeted case management per month

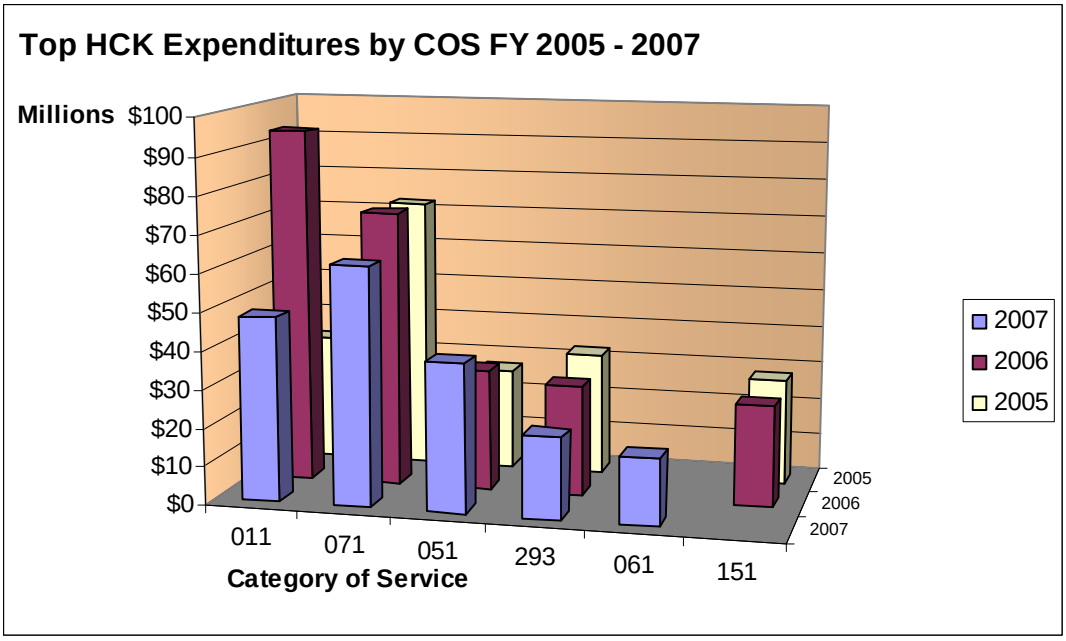
Spending by Category of Service

Examination of spending by type of service illustrates the impact of several policy changes in Medicaid and MediKan during 2005-2007. First, spending on inpatient hospital increased substantially in FY 2006 with the implementation of the health care assessment and access payment program, which increased hospital and physician reimbursement rates significantly. The health care access and improvement program uses an annual assessment on inpatient services provided by hospitals to improve and expand health care in Kansas for low income persons. The assessment paid by hospitals is used as a state match to draw down additional federal funding of approximately 40% state dollars and 60% federal dollars to support rate increases for both hospital and physician services. Secondly, total spending declined in FY 2007 as caseloads fell due to the implementation of federal citizenship and identity documentation requirements. And thirdly, KHPA transferred about 50,000 beneficiaries out of HCK and into HealthWave. Expenditure patterns are expected to change substantially again in FY 2008 as most mental health treatment is transitioned into the separately-funded and operated mental health PAHP.

HCK services are paid for through the Medicaid fee-for-service program. Most of the fee-for-service expenditures shown in aggregate in this program review are examined in more detail in separate program reviews. For example, a separate analysis of the fee-for-service prescription drug program examines trends and opportunities for enhanced safety and cost-effectiveness. Prescription drug spending is also a concern specifically for the MediKan population. The 2008 legislature required KHPA to develop a process to better manage prescribing and dispensing patterns for mental health drugs within the MediKan population. This process is to draw on the advice of mental health experts in Kansas to identify appropriate management interventions to improve

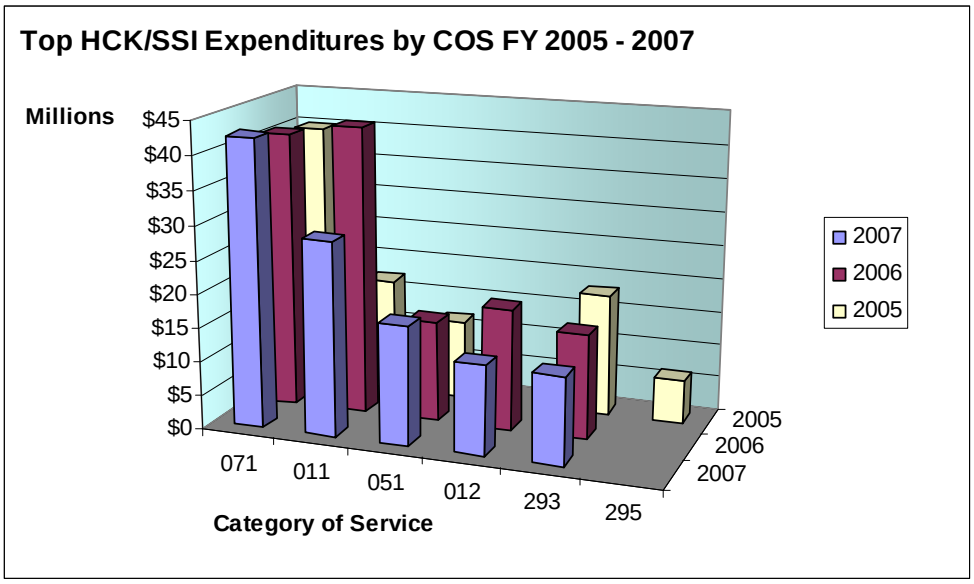
safety and cost-effectiveness in the MediKan population. The importance of this focus on prescribing and dispensing patterns in Medicaid and MediKan will become more apparent as mental health spending is transferred to the PAHP in FY 2008, and the proportion of (remaining) HCK expenditures attributable to hospital, prescription drugs, and physician services increases.

Figure 13



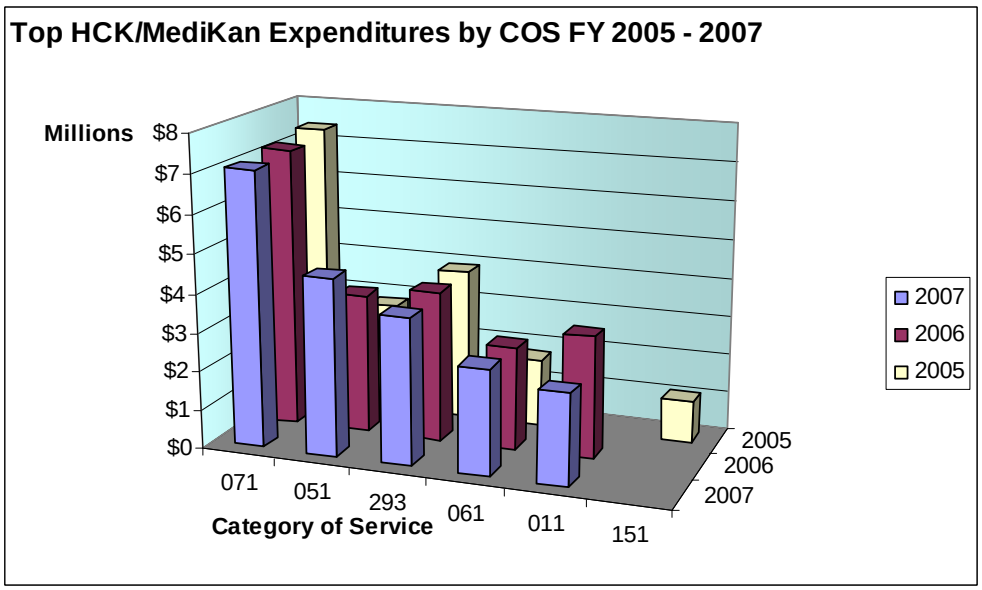
- 011 General Hospital (Inpatient)
- 071 Prescribed Drugs
- 051 Physician, Osteopath, Physician Group
- 293 Community Mental Health Center (CMHC)
- 061 General Hospital (Outpatient)
- 151 EPSDT Screening Services (KAN Be Healthy)

Figure 14



- 071 Prescribed Drugs
- 011 General Hospital (Inpatient)
- 051 Physician, Osteopath, Physician Group
- 012 Public Teaching Hospital (Inpatient
- 293 Community Mental Health Center (CMHC)
- 295 Local Education Agency/Early Childhood Intervention

Figure 15



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Quality Issues

HealthConnect Kansas Consumer Services and Satisfaction

KHPA receives input from HCK beneficiaries in a variety of ways, providing an indication of beneficiary satisfaction, customer service, and overall program performance.

The Quality Assistance Team (QAT) at KHPA's fiscal agent, EDS, assists with beneficiary and provider inquiries and grievances for both HCK and Medicaid fee-for-service beneficiaries. The QAT is composed of nurses, billing and reimbursement specialists, as well as social work staff. Provider and consumer issues from the QAT may be referred to EDS staff, KHPA program management staff, the Medicaid and Fraud Control Unit (MFCU) at the Kansas Attorney General's Office, state licensing boards, or other regulating authorities. Currently, HCK and FFS population grievances are reported in a combined report to the State. The State has requested grievances be broken down into the HCK and FFS populations so that comparisons can be made between the programs.

KHPA also solicits feedback from HCK beneficiaries through annual surveys administered by the agency's external quality review organization (EQRO), which in 2007 was the Kansas Foundation for Medical Care. In Figures 16 -18 below, results from the 2007 HealthConnect Kansas Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey are compared with the National CAHPS Benchmarking Database. The benchmarks consist of average scores for persons enrolled in public health plans across the Midwest and the nation.

Three rating questions reflect overall satisfaction with the care provided at the physician office level. Survey participants were asked to rate their satisfaction with their personal doctor/health provider, specialist, and all health care on a scale from 0 to 10, where 0 was the worst possible and 10 was the best possible. The scores below represent the percentage of respondents who indicated ratings of either 9 or 10.

Figure 16

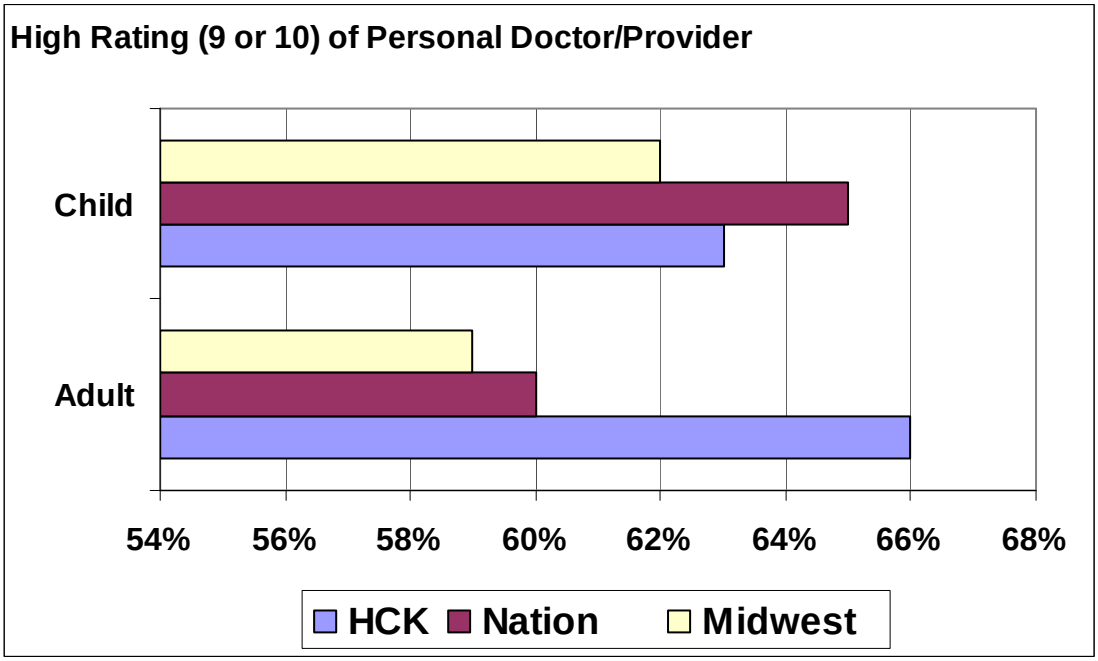


Figure 17

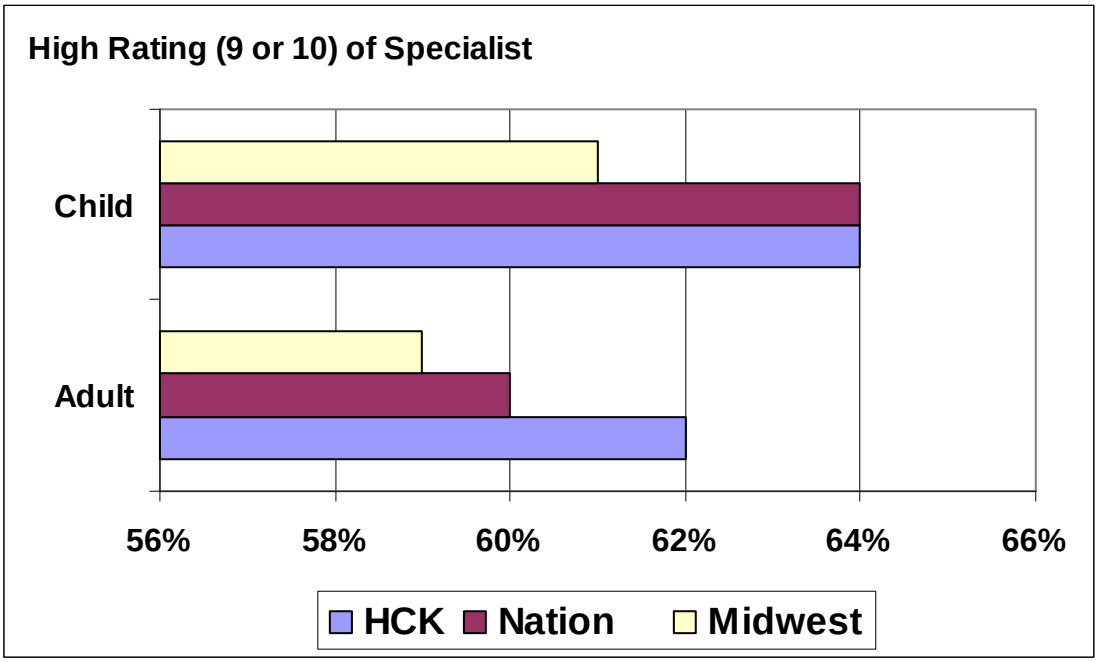
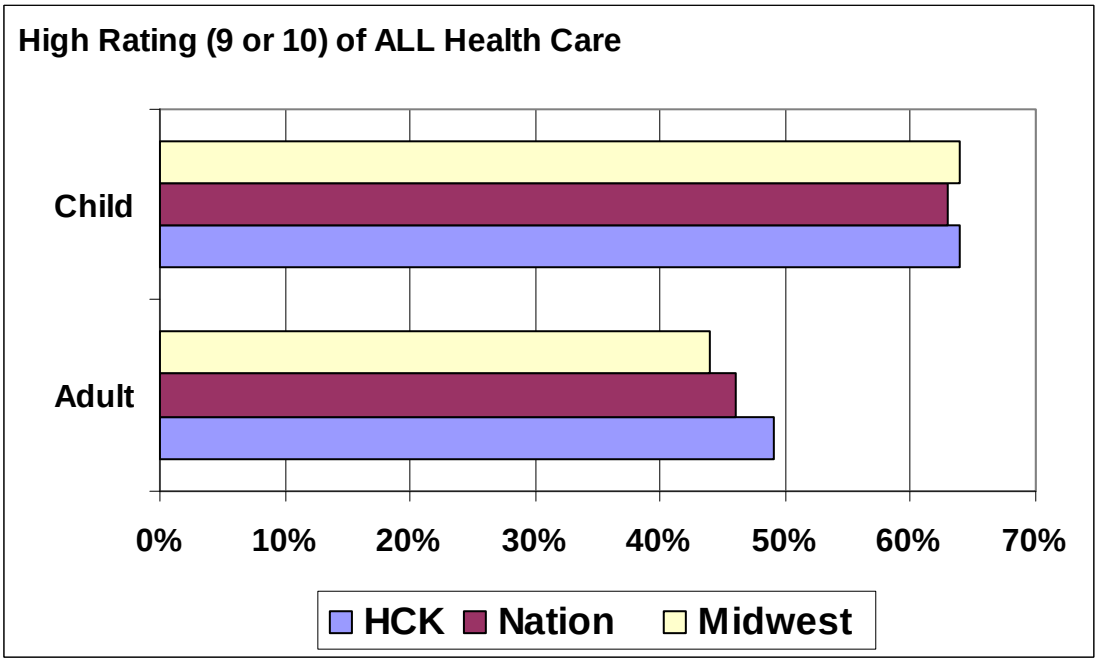


Figure 18



Overall, these comparisons indicate that many HCK beneficiaries were very satisfied with their personal doctor/provider and specialist as well as with the overall quality of health care. HCK adults were more satisfied than the national and Midwest benchmarks with their personal doctor/provider, specialist and overall health care. Parents of children enrolled in HCK expressed levels of satisfaction with their personal doctor specialist and overall health care /provider that were on par with national and Midwestern benchmarks.

The CAHPS surveys also include measures referred to as composites. Composites are groupings of two or more questions that measure the same dimensions of health care or health plan services, and have the same response options, enabling a comparison of adult and child responses to each

other as well as to national and regional benchmarks. While some of the composite attributes were different in the Adult and Child surveys, they measured the same dimensions of care. Figures 19-21 below display the percentage of surveyed beneficiaries with the most positive responses (e.g., "Not a Problem" or "Always") to questions contained in the composites.

Figure 19

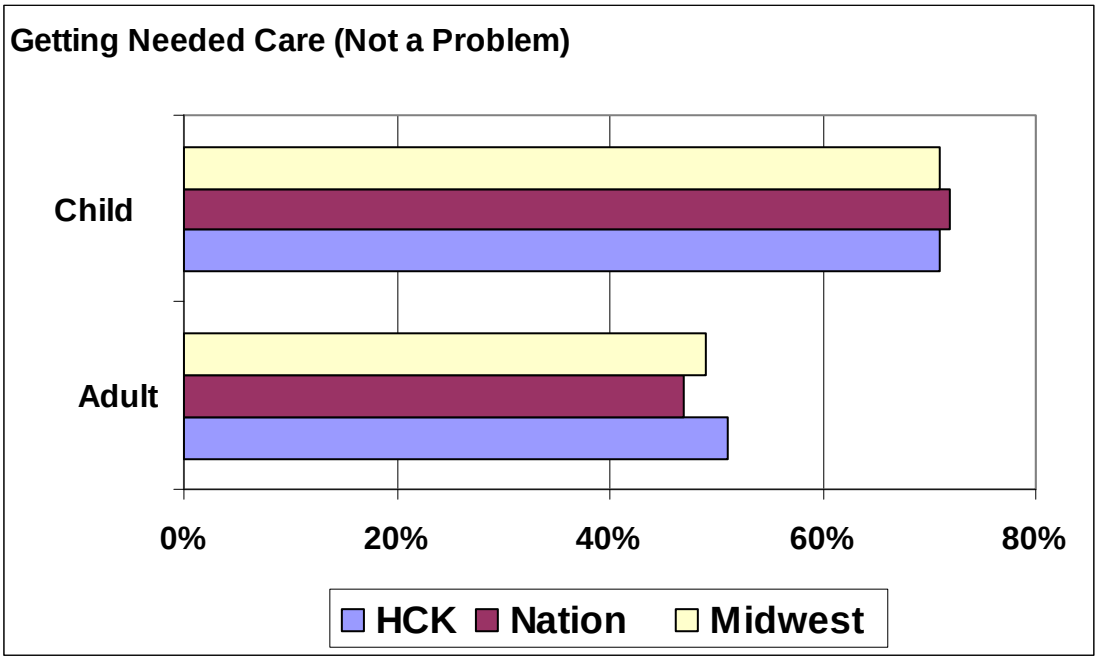


Figure 20

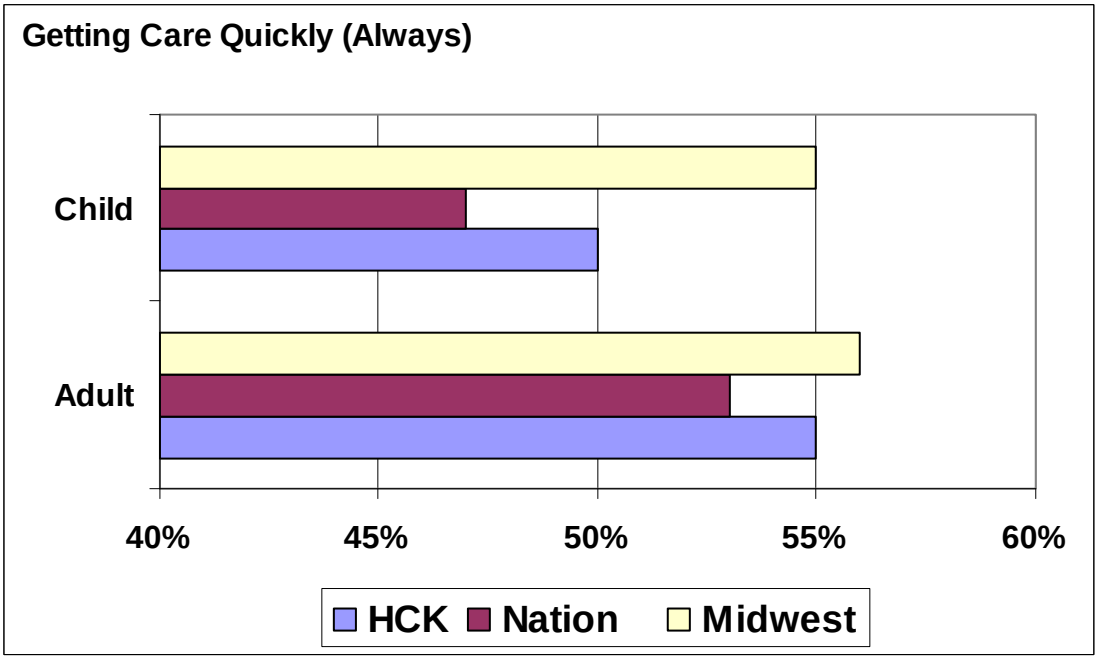
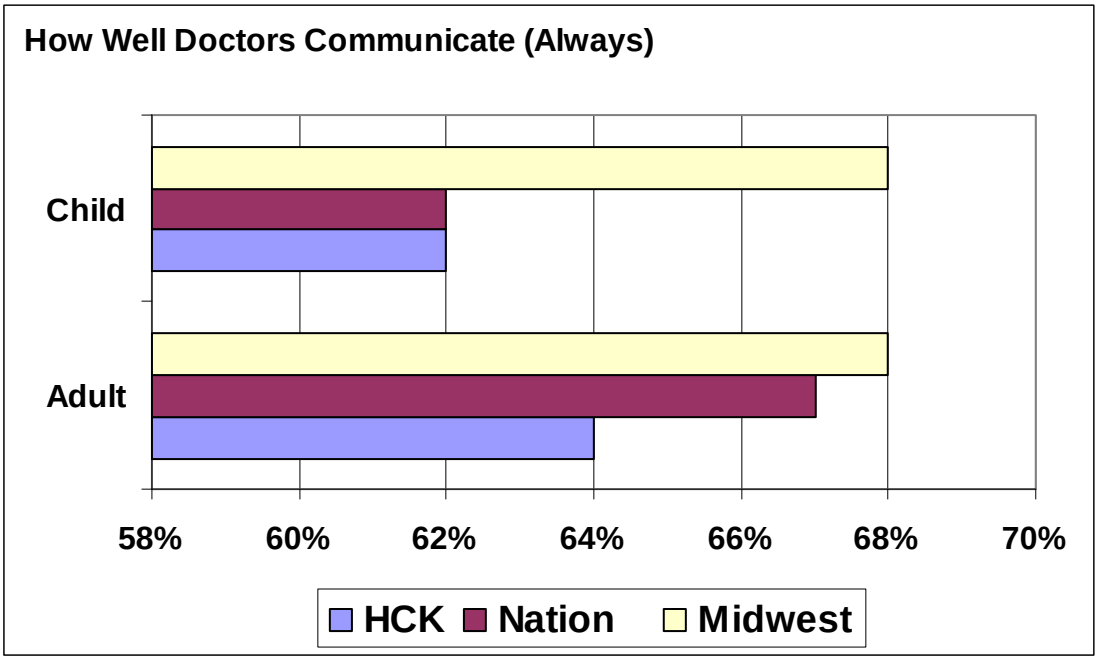


Figure 21



Many HCK beneficiaries reported high scores for Getting Needed Care, Getting Care Quickly and How Well Doctors Communicate. However, some opportunities for improvement were identified based on comparisons to the Midwest. These areas are Getting Care Quickly (Child) and How Well Doctors Communicate (Adult and Child). The composite attribute questions with the lowest scores in these areas involved:

- Getting care as soon as was wanted when care was needed right away (Child)
- Showing respect for what parent or guardian had to say (Child)
- Explaining things in an understandable way (Child)
- Spending enough time with patient (Child)
- Listening carefully (Adult and Child)

A brochure providing an overview of the CAHPS survey results was sent to all HCK providers in spring of 2008. When routine provider workshops are conducted around the state by KHPA's fiscal agent, emphasis will be placed on the lowest score issues cited above. These opportunities for improvement also correspond with some of the outcomes associated with the implementation of a medical home, a core objective for the KHPA and a specific objective associated with health reform in Kansas.

A KHPA quality improvement plan is being implemented in FY 2009 that seeks to create more comparable performance and outcomes information across health plans, including HealthWave and HealthConnect. KHPA is also proposing to implement new data collection for quality improvement purposes within the fee-for-service program, which would provide additional comparative information across programs. This would create, for example, the opportunity to identify the value added by the HCK program's PCCM as compared to performance in the less structured fee-for-service program and the more structured HealthWave program.

HealthConnect Kansas Provider Participation and Satisfaction

KHPA engages providers in a number of ways at the agency and program level to assist in identifying policy issues, administrative concerns, coverage levels and other programmatic issues. Two sources of information are of particular relevance in the administration of the HCK PCCM program: the Peer Education and Resource Council (PERC) and provider surveys.

The PERC is composed of KHPA representatives, fiscal agent representatives and at least six enrolled Kansas Medical Assistance Program (KMAP) providers. PERC assists with provider education, development and review of improvement plans for providers, peer review and recommendations for policy change for HCK and Title 19 fee-for-service (FFS) beneficiaries. Coupled with the resolution of individual provider issues, PERC provides feedback for managed care initiatives. For example, input from PERC was instrumental in helping to manage a smooth transition of approximately 50,000 HCK beneficiaries to the HealthWave (HW) program in January 2007, when they were reassigned to their choice of either UniCare Health Plan of Kansas (UniCare) or Children's Mercy Family Health Partners (CMFHP).

During 2007, KHPA's External Quality Review Organization (EQRO) fielded a provider satisfaction survey for HCK, while each of the HealthWave MCOs were required to do develop and administer their own provider surveys. KHPA required the HealthWave MCOs to include at least four questions in common with the HCK survey to enable comparisons across plans and managed care programs. They consisted of scaled responses to each of the following statements:

- In comparison to all of your other patients, (HCK/Children's Mercy Family Health Partners (CMFHP)/UniCare) patients are just as educated regarding the use of their medical insurance cards.
- In comparison to your patients in other health plans, (HCK/CMFHP/UniCare) patients have as much access to the tests and treatments they need.
- In comparison to your patients in other health plans, (HCK/CMFHP/UniCare) patients have as much access to the prescription drugs they need.
- I am satisfied with being a PCP/PCCM in the (HCK/CMFHP/UniCare) program.

Responses to these questions were predominately positive, and reflect an overall satisfaction in these key areas, with the most opportunity for improvement being in beneficiary education. The distribution of responses is provided in Figures 22 - 25. In 2008, the administration of provider surveys for both HealthWave and HealthConnect will be consolidated with KHPA's EQRO. This will allow for significant increases in the number of comparable questions and enhanced uniformity in the selection of providers to be included in the survey.

Figure 22

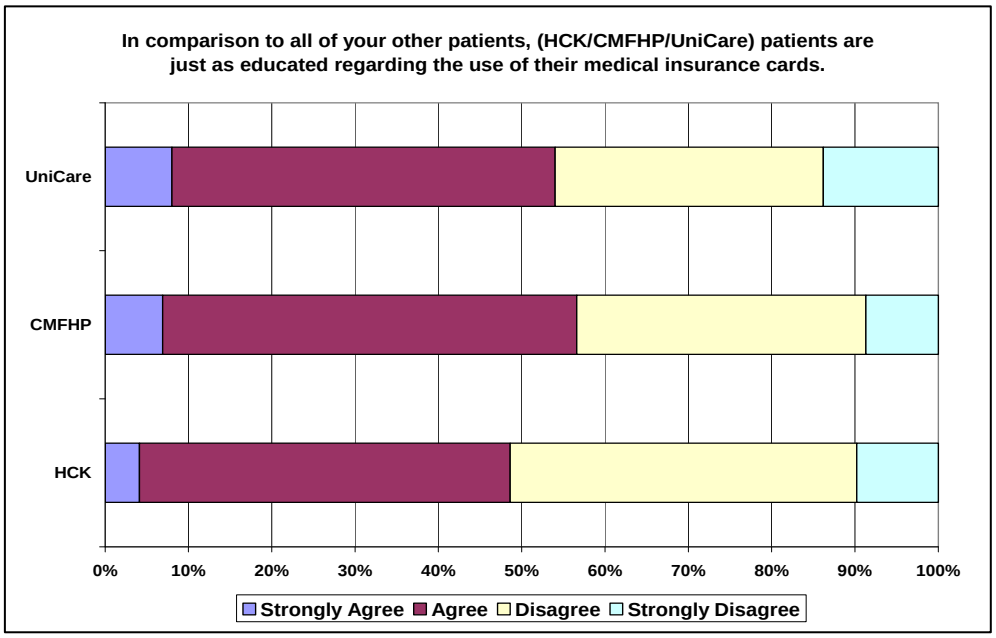


Figure 23

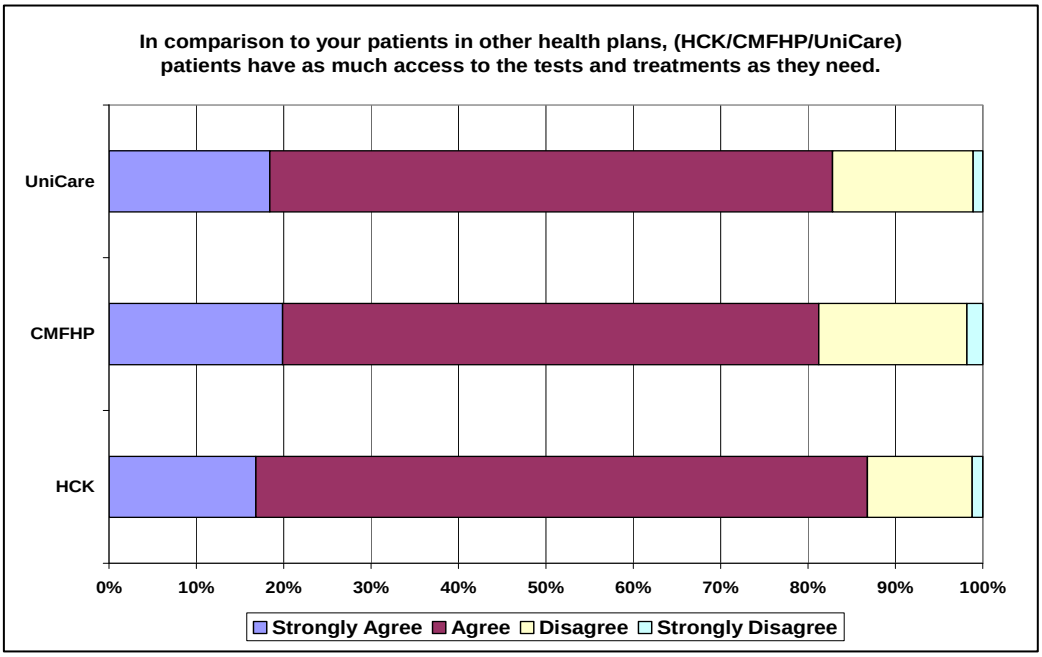


Figure 24

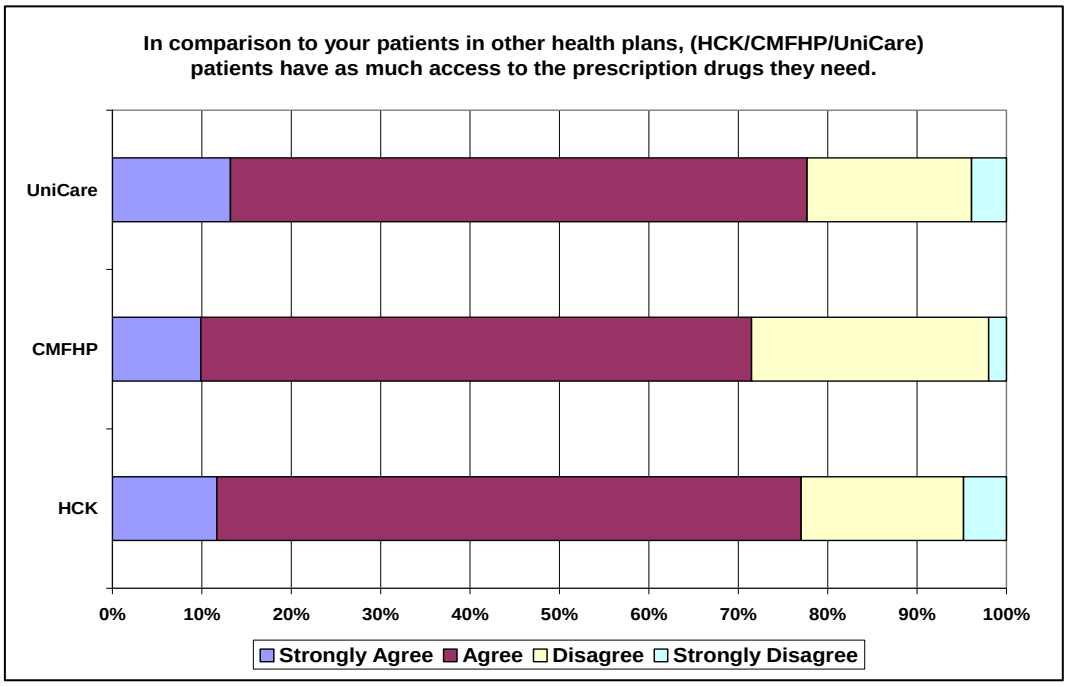
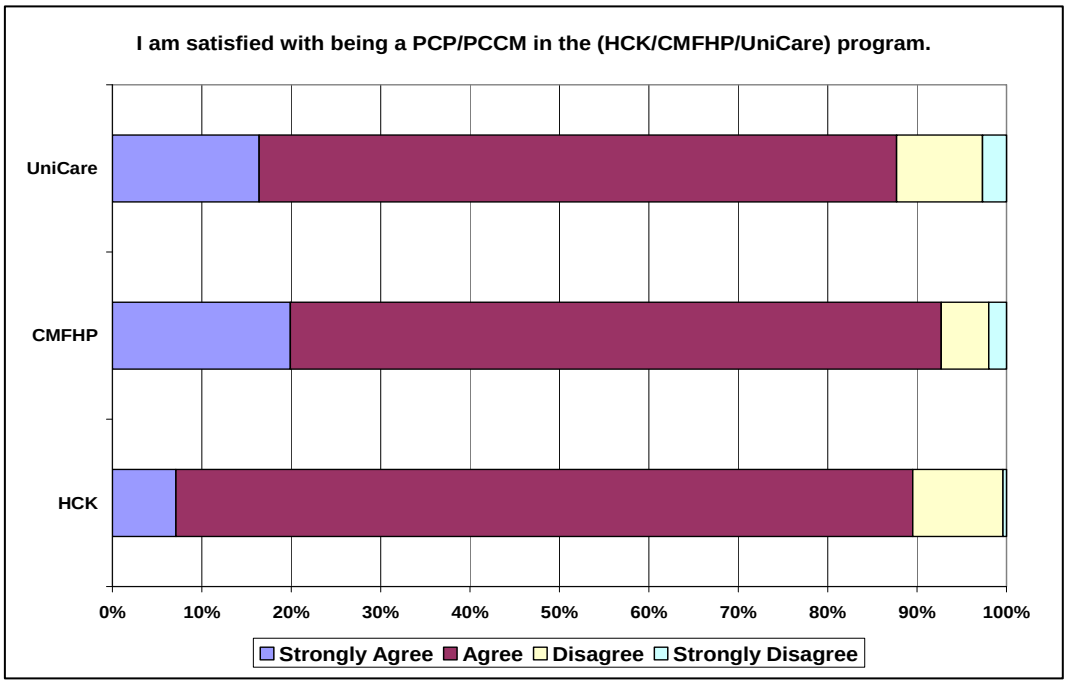


Figure 25



Access to Primary Care and a Medical Home

KHPA contracts directly with providers to act as PCCMs. Table 3 represents the capacity of the HCK program by displaying the actual caseload of each type of PCCM and the maximum caseload possible. The table outlines caseloads at a consistent point in time in each of three years examined -- June 2005, 2006, and 2007. A provider in HCK may contract for up to 1,800 beneficiaries. Many HCK PCCMs contracted for the maximum allowed caseload; however, some geographic areas may not have enough beneficiaries to support full caseloads.

None of the provider categories area operating close to their contractual maximum for caseload at the statewide level. Overall capacity significantly exceeds enrolled caseload, with enrollees at about 15% of contractual maximum in 2005 and just 4% in 2007, after the transfer of TAF and PLE beneficiaries to HealthWave. Two potential cautions are in order in assessing access to PCCMs for HCK beneficiaries. First, HCK providers also contracting to provide service in the HealthWave program may choose to limit access to HCK (or fee-for-service Medicaid) beneficiaries, a decision that may not be reflected in the 2007 totals for maximum caseloads. Second, the information in Table 3 has not been analyzed at the regional and county level, and does not identify potentially underserved areas around the state. With these cautions in mind, we conclude nonetheless that aggregate capacity for primary care in HCK is sufficient.

Table 3

Focus	Number of Providers			Total Current Caseload			Total Max Caseload		
	2005	2006	2007	2005	2006	2007	2005	2006	2007
Family Practitioner with Obstetrics	94	95	91	11,454	10,917	3,243	73,581	73,316	66,830
General Practitioner with Obstetrics	3	3	3	167	132	49	3,620	3,620	2,320
Internal Medicine	53	53	53	1,960	1,677	992	12,853	14,298	10,451
General Practitioner	35	31	26	4,505	4,388	1,602	19,555	19,650	18,850
OB/GYN	13	13	14	1,099	928	209	16,410	14,622	14,682
Pediatrician	81	86	82	23,155	22,550	3,890	85,926	88,458	83,863
Family Practitioner	197	210	218	18,858	17,302	6,150	102,148	95,779	95,132
Nurse Practitioner	7	13	13	338	864	633	1,090	11,150	10,660
FQHC- Federally Qualified Health Clinic	13	13	12	5,377	5,125	2,042	44,853	44,853	42,303
RHC- Rural Health Clinic	131	138	143	19,464	18,790	5,180	209,670	222,095	229,755
IHC- Indian Health Clinic	2	2	0	4	19	0	10	10	0
Local Health Department	0	1	2	0	69	11	0	25	10
Mid-Wife	1	1	2	29	22	2	20	20	270
Pediatrician and Internal Medicine	7	6	6	676	750	234	850	950	575
Multi-specialty Group (Mixed Specialty)	8	8	8	2,742	2,188	701	37,040	36,940	37,040
OB/GYN and Primary Care	1	1	1	77	70	8	1,800	1,800	1,800
Physician Assistant	2	1	1	150	43	1	150	50	50
Statewide Total	**648**	**675**	**675**	**90,055**	**85,834**	**24,947**	**609,576**	**627,636**	**614,591**
Capacity (% of assigned caseload)							**15%**	**14%**	**4%**
Average Slots per Provider							**941**	**930**	**911**

As measured by standard patient-to-provider ratios for the state as a whole, HCK has historically provided good access to medical services for beneficiaries. The $2 monthly fee may induce some level of participation, and reimbursement rates for many physician services were increased in FY 2006. These enhancements haven't been formally evaluated to assess their impact on participation, but informal feedback from the physician community consistently points to their positive role in securing access to primary care for beneficiaries. However, most rates remain below Medicare, and are even further below privately-negotiated reimbursement with other insurers. As expected, Medicaid is not able to "buy" its way into physician and other primary care offices through competitive reimbursement.

There may be a number of other reasons for continued participation in HealthConnect. Coverage policies support wide participation of health professionals serving as PCCMs: In addition to primary care physicians, nurse practitioners and specialists such as OB/GYNs are also enrolled as PCCMs, and physician assistants were allowed to be enrolled as PCCMs effective August 2004. Still, the vast majority of individually-contracted PCCMs are in family practice or are pediatricians. The majority of PCCMs operate in a clinic setting, headed by physicians with nurse practitioners and physician assistants operating under their purview.

Although difficult to quantify, the State's primary care providers clearly express a professional obligation to serve the state's Medicaid and uninsured populations. While rates, coverage and reimbursement policies, and administrative procedures are routinely raised as concerns by participating providers, it is also apparent in their interaction with KHPA public insurance programs that Kansas primary care providers as a whole operate with an ethical commitment to these programs. A number of providers have served for decades. In recognition of their longstanding commitment, in September of 2007, a thank you letter signed by the Governor was sent to 98 HCK PCCM providers and fee-for-service providers that had 30 years or more service to the State.

The information presented in Table 3 suggests that the issue of "access" to primary care is not a significant issue for most HCK beneficiaries (since most beneficiaries reported adequate access). Access to primary care, however, is an important first step in ensuring an effective medical home, an especially critical step for the HCK program. A separate analysis of the health needs of the high-cost populations that now dominate the HCK and fee-for-service programs is included in the review of medical services for the aged and disabled [see Chapter 13]. That analysis provides a number of examples of gaps in the quality of care received by some the disabled, and identifies a number of alternative systems of care that could be advanced in Kansas to promote additional components of a medical home. One approach is currently being tested by KHPA in Sedgwick County. The Enhanced Care Management Program (ECM), a pilot project in Sedgwick County, is comprised of HCK members. Since March 1, 2006, the ECM project has provided home-based care management services to ECM members. Assessment will continue to determine if more intense management of high cost populations is cost effective. This pilot and several alternatives are discussed in more detail in Chapter 13.

Conclusions

The HCK program has been transformed in the last year from a statewide "managed care alternative" for Medicaid beneficiaries, to a much smaller program focused primarily on providing primary care for SSI and MediKan disabled beneficiaries. The remaining population experiences a high prevalence of chronic disease, including diabetes, heart disease and mental illness. While costs have decreased significantly due to the exit of more than 50,000 beneficiaries, KHPA analy-

sis of Medicaid spending consistently highlights the growing costs of the disabled, and the prominent role these costs play in driving overall Medicaid spending. Costs for conditions such as heart disease and diabetes is expected to rise in relative importance in HCK and in the management of Medicaid's medical services as the funding and management of mental health services was transferred into the PAHP, a separately-operated mental health managed care program in July 2008: The chronic medical conditions of the SSI and MediKan populations merit an increasing focus as KHPA seeks alternative means of delivering cost-effective care, an emphasis reflected in the separate 2008 program review focused on medical services for the aged and disabled.

The HCK program consists primarily of a primary care provider, a PCCM that receives a small per-member-per-month fee of $2 to serve as manager and gatekeeper for each HCK beneficiary's care. This program review confirms an overall level of access to primary care providers within HCK, but there is limited evidence of the impact of the PCCM program on beneficiary health care and health outcomes. The PCCM program was initiated to increase access to primary care, but other aspects of the medical home have not yet been applied within HCK, leaving many of KHPA's highest-cost, highest-need beneficiaries without a coordinated and cost-effective system of care.

This program review summarizes results of beneficiary and provider surveys which indicate a relatively high level of satisfaction with the HCK program. More objective measures of the quality of health care received by this population suggest a number of potential opportunities for improvement. These results are discussed in detail in Chapter 13. The perceived value of the PCCM approach in promoting higher-quality care can also be observed in beneficiaries' choices. It is apparent from the information presented in this program review that many high needs beneficiaries who have a choice are not selecting HCK, indicating the lack of perceived added value in the PCCM approach. The role of the PCCM system in supporting primary care and a medical home within Medicaid will be a central question in KHPA's review of care management approaches for the aged and disabled during FY 2009.

Recommendations

The HCK program has experienced dramatic changes in both covered populations and services during FY 2007 and 2008. The KHPA does not recommend any further changes in the HCK program in FY 2009. However, recommendations from other program reviews may have a direct bearing on the HCK program and its population that could lead to further transformation of the program in future years:

1. The chronic medical conditions of the SSI and MediKan populations merit an increasing focus as KHPA seeks alternative means of delivering cost-effective care, an emphasis reflected in the separate 2008 program review focused on medical services for the aged and disabled. The role of the PCCM system in supporting primary care and a medical home within Medicaid will be a central question in KHPA's review of care management approaches for the aged and disabled during FY 2009.

2. A KHPA quality improvement plan is being implemented in FY 2009 that seeks to create more comparable performance and outcomes information across health plans, including HealthWave and HealthConnect. KHPA is also proposing to implement new data collection for quality improvement purposes within the fee-for-service program, which would provide additional comparative information across programs.

3. Develop linkages between HealthConnect PCCMs and the Social and Rehabilitation Services Mental Health and Substance Abuse providers to better coordinate physical care with Mental Health/Substance Abuse.