Chapter 13: Medical Services for the Aged and Disabled

Executive Summary

Description

The aged and disabled population in Kansas accounts for 33% of the Medicaid population, but 67% of total Medicaid spending. Almost half (47%) of the growth in Medicaid from FY 2007 to FY 2009 can be attributed to the aged and disabled; 39% attributed to the disabled and 6% to the aged. The top Medicaid cost drivers for the aged and disabled include: inpatient services, pharmacy, outpatient services, mental health services, hospice and Medicare premiums and co-pays. Inpatient services represent the highest costs among the Supplemental Security Income disabled category, accounting for 71% of the $183.83 million of inpatient costs. Pharmacy is the second highest cost driver for the disabled.

Kansas Medicaid FY 2007	Supplemental Security Income - Disabled*	Medically Needy - Disabled (SSI)	Supplemental Security Income - Aged*	Medically Needy - Aged (SSI)	Qualified Medicare Beneficiary
Average Monthly Caseload (number of people)	32,798	16,591	6,305	17,114	8,156
Total Medical Costs	$336.51 million	$107.56 million	$29.39 million	$61.58 million	$11.13 million
Average Monthly Costs (per person) paid by Medicaid	$855	$540	$388	$300	$114
Top Three Medicaid Cost Drivers	Inpatient Pharmacy Mental Health	Inpatient Pharmacy Medicare Premiums and Co-pays	Medicare Premiums and Co-pays Inpatient 3. Pharmacy	Hospice Medicare Premiums and Co-pays Inpatient	Medicare Premiums and Co-pays Inpatient Outpatient

*The Supplemental Security Income (SSI) program pays monthly benefits to disabled adults and children who have limited income and resources.

Key Points

- Medical expenditures for the aged and disabled population are projected to show steady increases in 2008 and 2009.
- Using funds from a Center for Medicare and Medicaid Services (CMS) transformation grant awarded to KHPA, we looked at whether we could improve preventive care to the aged and disabled. Our analysis showed:
    - Preventive care opportunities are being missed for beneficiaries struggling with diabe-

tes, depression, coronary artery disease, hypertension, congestive heart failure, and asthma.

- Preventive care opportunities are also being missed for cancer screenings, cardiac event prevention, osteoporosis screening, and pain management.

- The overall trends in expenditures and the implications of chronic health conditions that plague the aged and disabled population suggest the need to more effectively manage and support the needs of this population. KHPA is currently conducting two pilot projects that aim to improve health outcomes for people with disabilities:
  - The "Health Promotion for Kansans with Disabilities" pilot project, the CMS Transformation Grant program to identify and improve primary care needs among the chronically ill, and
  - The "Enhanced Care Management" pilot program targeting high-cost Medicaid beneficiaries in Sedgwick County for intensive care management.
- Given the high incidence of chronic illness and the high level of interaction with the medical system, the need to implement a medical home model of care is significant for the aged and disabled. Goals for improving care in this population mirror closely the established goals of a patient-centered medical home.

KHPA Staff Recommendation

- Develop and utilize a medical home model of care for the aged and disabled population. The development of a medical home model for Kansas is currently underway with the passage of Senate Bill 81 during the 2008 legislative session. A large group of stakeholders will design over the next year a care management model based on existing evidence and the needs of our state. The recommendations will be brought to the KHPA Board in 2009 for consideration in development of the FY 2011 budget.

Program Overview

Established in 1965, Medicaid has become the largest single source of financing for the long-term care of aged and disabled people who are low-income or who have depleted their income and assets on medical and long-term care expenses (Keenhan, Siska, Truffler, Smith, Cowan, 2008). As succinctly stated in a 1999 Urban Institute report, Medicaid spending for these beneficiaries "dominates" the program (Bruen, Wiener, Kim, Miazad, 1999). Nationally, while aged and disabled beneficiaries make up only 25% of the population, they account for nearly 70% of all Medicaid spending. In Kansas, during FY 2008, they accounted for about 33% of the population and 67% of Medicaid spending. Partly because long-term care services such as nursing home and community-based are so expensive, the aged and disabled are the costliest groups of people covered under Medicaid (Congressional Research, 2008). However, while long-term care services play a significant role in driving the costs for the aged and disabled, it is important to note that acute care spending for these individuals is also greater than it is for children, pregnant women, and parents.

Kansas' Medicaid expenditures for the aged and disabled compares with neighboring states both in aggregate and as a percentage of total state Medicaid spending. A 2005-2006 state Medicaid fact sheet developed by the Kaiser Commission shows this comparison.

State	% of State's FY 2005 Medicaid Enrollment			% of State's FY 2005 Total Medicaid Program Expenditures			FY 2005 Per Enrollee Medicaid Spending for the Aged	FY 2005 Per Enrollee Spending for the Disabled
	Aged	Disabled	Combined	Aged	Disabled	Combined		
Kansas	10	16	26	24	44	68	$15,044	$15,971
Colorado	9	14	23	26	39	65	$13,296	$12,925
Iowa	10	16	26	25	49	74	$14,575	$17,380
Missouri	8	15	23	25	43	68	$12,842	$12,050
Nebraska	9	13	22	26	40	66	$15,870	$17,539
Oklahoma	9	13	22	25	40	65	$9,592	$10,572

Note: Medicaid spending for the elderly and disabled includes long-term care costs. A regional breakdown of medical and long-term care costs is currently not available.

Introduction to the Population

There are five major categories of the aged and disabled among Kansas Medicaid beneficiaries. Although Medicaid eligibility is complicated, a simplified explanation of these categories follows.

Category	Beneficiary Description
Supplemental Security Income (SSI) – Aged	These are adults, 65 years of age and older, with low income and limited resources who receive SSI payments and are eligible for medical assistance. A large percentage of the individuals also receive Medicare benefits.
Supplemental Security Income (SSI) - Disabled	These are adults, under age 65, and children with disabilities who receive SSI payments and meet income guidelines for Medicaid.
Medically Needy – Aged (SSI)	People included in this category are over 65 and have incurred medical expenses to the extent that their income has been depleted to levels that make them eligible for Medicaid.
Medically Needy – Disabled (SSI)	These are people under 65 with disabilities that qualify them for coverage, but who have incomes that require them to spend a certain amount on medical services before Medicaid will cover them.
Qualified Medicare Beneficiary (QMB)	People in this group are certain low-income Medicare recipients, for whom Medicaid pays portions of Medicare premiums, coinsurance, or deductibles.

The monthly caseloads for each eligibility group are shown in Figure 1. These five separate groups comprise approximately 107,742 people served during FY 2007, based on eligibility throughout the fiscal year.

Figure 1

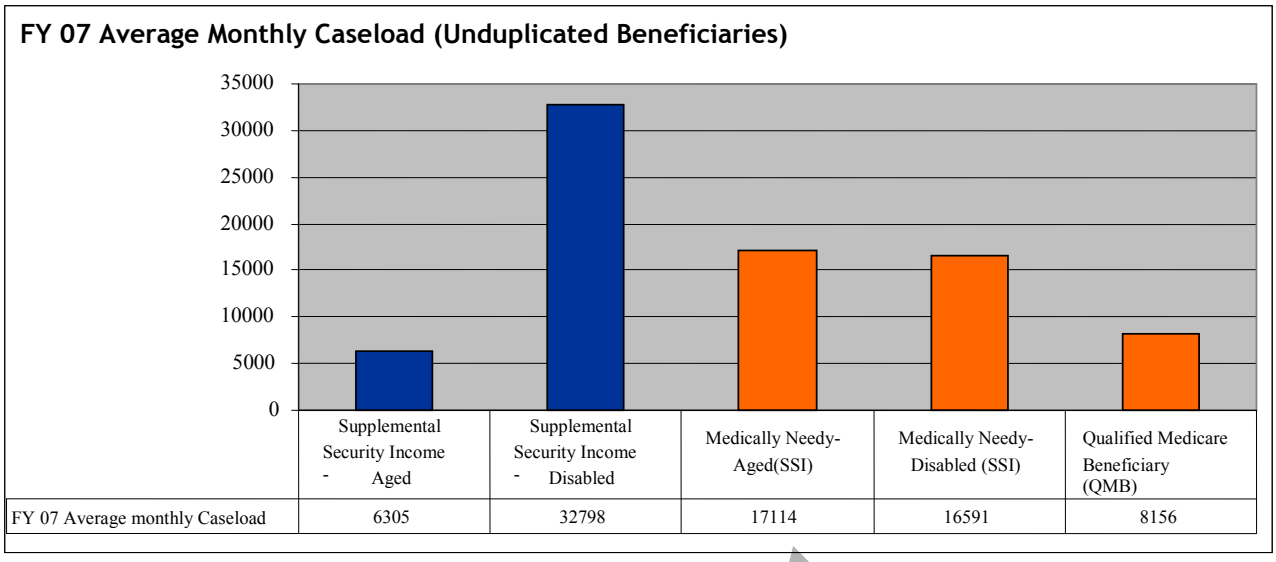


Table 1 depicts the top medical cost drivers, excluding long term-care costs, for each of the five eligibility groups.

Table 1
Top Medical Cost Drivers In Each Of The 5 Population Groups by Agency

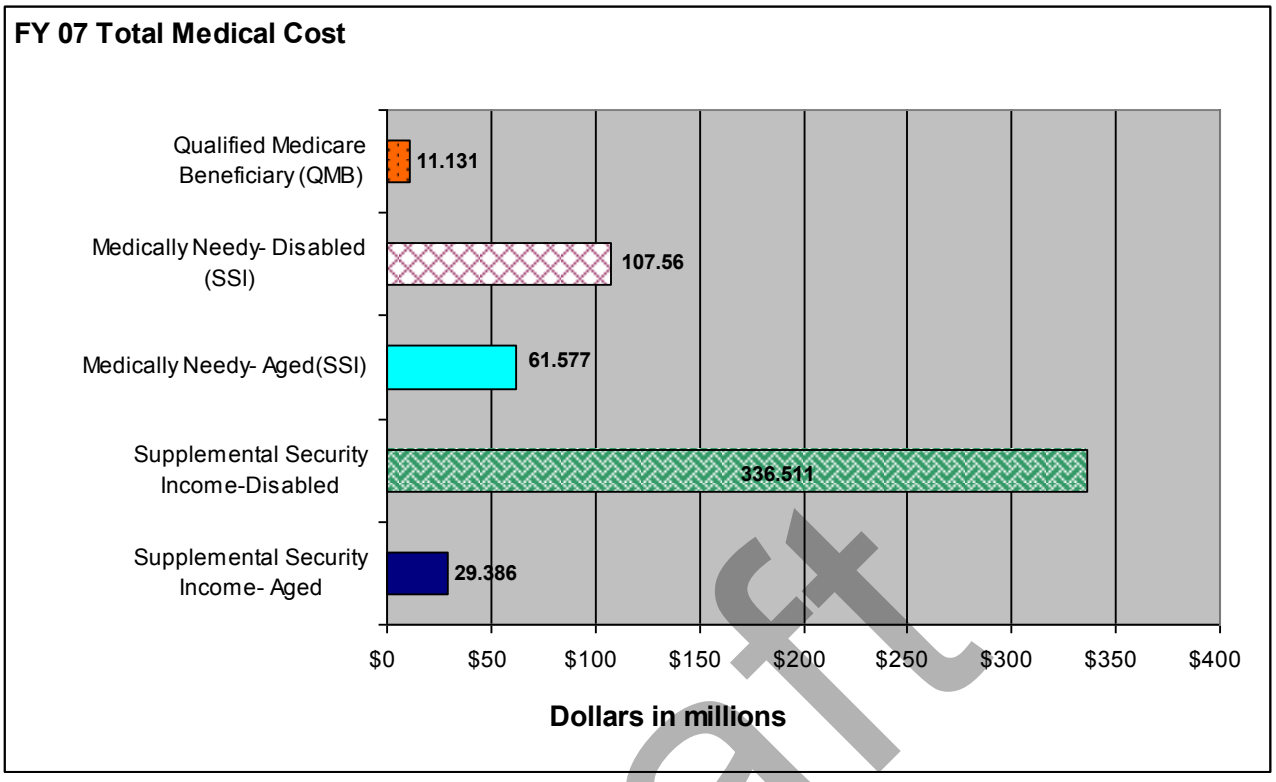
Type of Service by Agency	Supplemental Security Income - Aged	Supplemental Security Income - Disabled	Medically Needy - Aged (SSI)	Medically Needy - Disabled (SSI)	Qualified Medicare Beneficiary (QMB)
Mental Health- SRS		$28,510,000			
Inpatient - KHPA	$9,055,000	$131,072,000	$9,256,000	$33,328,000	$1,123,000
Outpatient - KHPA					$263,000
Pharmacy - KHPA	$2,729,000	$80,124,000		$14,378,000	
Hospice- KHPA			$19,358,000		
Medicare Premiums and Co-pays KHPA	$9,174,000		$18,429,000	$12,708,000	$9,308,000

Cost drivers for the aged reflects the role that Medicare plays in funding health care services. Medicare not only helps pay for health care benefits such as hospitalizations and physician services but also provides prescription drug coverage through Medicare Part D. Medicare Part D was implemented in 2006 to cover pharmacy costs for Medicare beneficiaries. Prior to that, individuals "dually eligible" for Medicare and Medicaid received their pharmacy benefit through Medicaid. Pharmacy for the disabled is among the top cost drivers primarily due to the treatment of chronic conditions, as well as the significant use of mental health drugs.

Figure 2, listed below, shows a breakdown of total medical costs (excluding long-term care costs) per eligibility group for FY 2007. The total medical expenditures for all five groups is $546,165,000, representing approximately 45% of the total medical expenditures for Kansas Medicaid during that year. When long-term care costs are included, expenditures increase to $1,405,695,000, representing approximately 67% of the total expenditures for Kansas Medicaid

during FY 2007.

Figure 2



Long-Term Care Coverage Options in Kansas

People who receive Medicaid long-term care are:

- Individuals with mental retardation and developmental disabilities
- Individuals with mental illness
- Individuals with spinal cord injuries and traumatic brain injuries
- Individuals with Alzheimer's disease and dementia
- Individuals with neuro-degenerative conditions
- Children with special health care needs.

Contributing to the high cost of providing coverage to these beneficiaries is not only the nature of their disabilities and complex needs, but also the fact that many have multiple chronic conditions (Kronick, Bella, Gilmer, Somers, 2007). Data reported by the Center for Health Care Strategies (CHCS) show that beneficiaries with three or more chronic conditions are responsible for a significant portion of the nation's Medicaid spending, and that for people with disabilities, each additional chronic condition is associated, on average, with an increase in costs of approximately $8,400 per year (Kronick et al, 2007).

In Kansas, there are two options for receiving long-term care services through the Medicaid program: the Home and Community Bases Services (HCBS) waivers and the Nursing Facility Program (KHPA, 2007). These options are managed by Social Rehabilitations Services (SRS) and the Department of Aging (DOA). HCBS waivers currently being implemented in Kansas are:

Waiver Name	Beneficiaries Served
Frail Elderly (FE)	Individuals age 65 and older who need assistance living on their own
Traumatic Brain Injury (TBI)	Individuals 16 and older who have had a traumatic injury to the brain
Mental Retardation/Developmental Disabilities (MR/DD)	Individuals 16 and over who are mentally retarded or developmentally disabled
Physically Disabled (PD)	Individuals 16 and over who are physically disabled and need personal assistance with everyday tasks
Children with Severe Emotional Disturbance (SED)	Individuals under the age of 21 who meet the severely emotionally disturbed criteria
Technology Assisted (TA)	Individuals under the age of 18 who are dependent on mechanical ventilators or need intravenous support
Autism Waiver	For children from the time of diagnoses through 5 years of age

In addition to long-term care services provided through the waivers, nursing home services and intermediate care facilities for the mentally retarded are available to certain Kansas Medicaid beneficiaries.

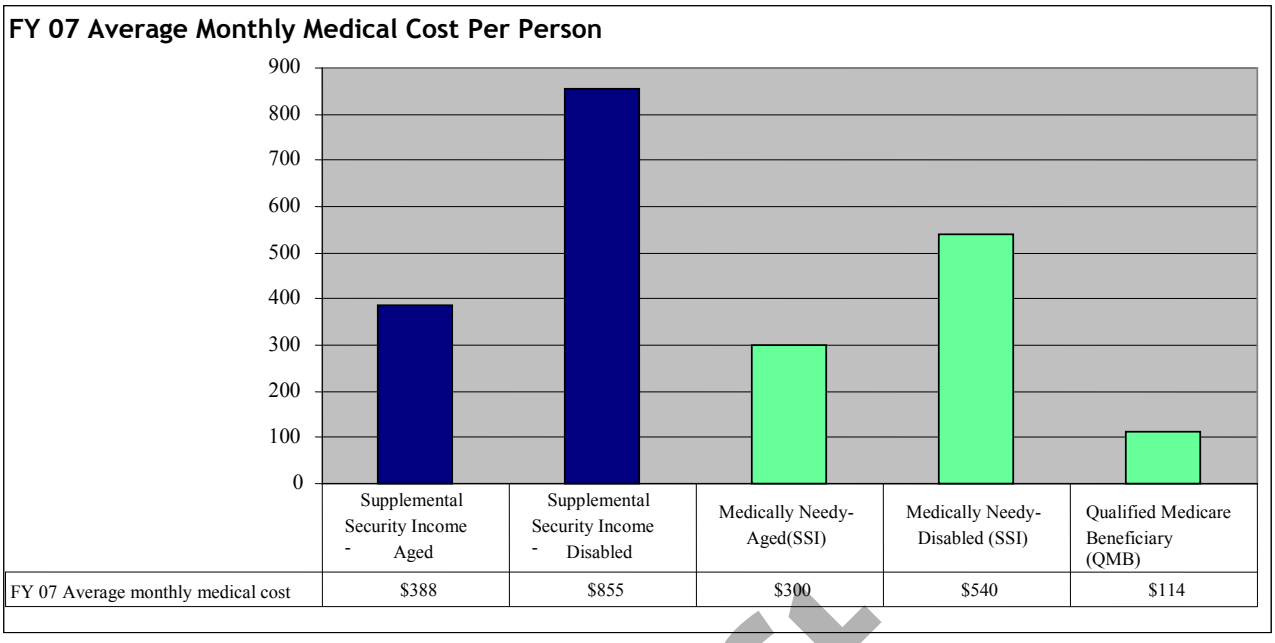
Behavioral health and substance abuse services are provided through two waivers (called 1915b): the Prepaid Ambulatory Health Plan (PAHP) and the Prepaid In-Patient Health Plan (PIHP). Both programs are managed by the Kansas Department of Social and Rehabilitation Services

Coverage of Medical Services

Kansas Medicaid coverage of medical services, or acute care, includes services such as physician and hospital care, prescription drugs, and laboratory and diagnostic testing. For some aged and disabled beneficiaries, who are dually eligible for Medicaid and Medicare, prescription drugs are now covered by Medicare Part D.

FY 2007 average monthly expenditures for these individuals, according to category of eligibility, are shown in Figure 3.

Figure 3



Differences in average costs across the five eligibility groups reflect the large extent to which Medicare pays for services for the SSI-Aged, the Medically Needy-Aged (SSI), and the Qualified Medicare Beneficiaries (QMBs). It is important to note that the medically needy beneficiaries are comprised of people whose income is too high for regular Medicaid but who become eligible for a medically needy program by spending down their excess income on health care services. Because medically needy beneficiaries enrolled in Medicare receive pharmacy coverage through Part D, eliminating (or postponing) significant out-of-pocket expenses on prescription drugs, they may not be able to spend-down as quickly and experience lapses in their Medicaid eligibility. When these lapses occur, they lose access to health services covered by Medicaid (e.g., mental health services, drugs not covered by Medicare, etc.).

Figure 4

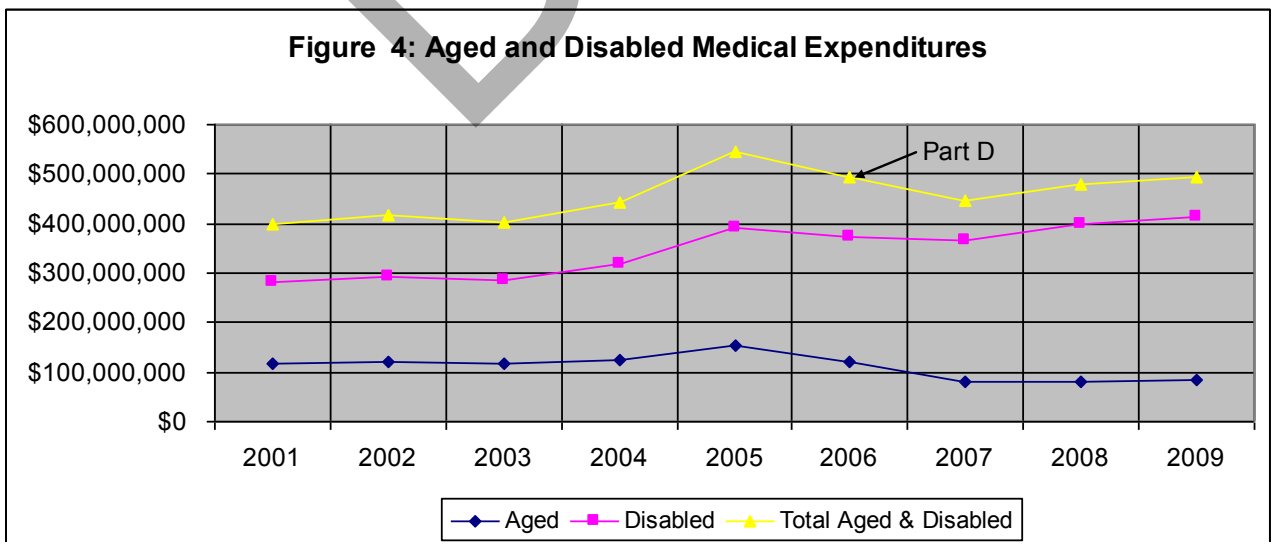


Figure 4 represents the medical expenditures for the aged and disabled across fiscal years 2001 through 2007, with expenditure projections included for 2008 and 2009. Contributing to the peak in spending in FY 2005 was an increase in the number of weeks comprising that year (i.e., 53 weeks instead of the normal 52 weeks), and pending of claims from FY 2004. In addition, Medicare Part D pharmacy benefits were implemented January 1, 2006, with the first full year of impact reflected in the FY 2007 expenditures.

Further analyses of the contribution of each Kansas Medicaid population to overall growth in Medicaid medical service costs for fiscal years 2007 through 2009 illustrates the importance of the aged and disabled populations in addressing overall Medicaid spending. KHPA analysis presented to the Board in June 2008 was based on each population's total enrollment and cost per beneficiary. The percentage of growth attributed to the aged and disabled when compared to all other populations was a combined 46.6% (i.e., 6% of the growth was attributed to the aged while 40.6% was attributed to the disabled) from FY 2007 to FY 2009. These findings along with trends in expenditures and our understanding of the implications of chronic health conditions that help define these populations, suggest the need to take a close look at opportunities to more effectively manage and support these high cost groups.

The Impact of Chronic Conditions

National Information

Recently, a number of states have focused health reform efforts on ways to provide better, more cost effective care to Medicaid beneficiaries who are aged or disabled. The Center for Health Care Strategies (CHCS), a nonprofit health policy resource foundation funded by national health care and corporate philanthropies and federal agencies, has served as a resource to states interested in health reform for the aged and disabled. CHCS has collected a wealth of information on the impact multiple chronic conditions have on this population and identified ways to improve quality of care, health outcomes, and better manage health care costs.

In a March 2008 issue brief entitled *Medicaid Best Buys: Improving Care Management for High-Need, High Cost Beneficiaries,* CHCS reported a number of national key findings on the aged and disabled, including:

- A remarkably small number of Medicaid beneficiaries with significant needs drive the majority of program spending.
- People with more than $5,000 in annual Medicaid costs make up less than 15% of total beneficiaries, but account for over 75% of all spending. Among these high-cost beneficiaries, virtually all have multiple physical and behavioral health conditions, disabilities, and/or frailties associated with aging.
- Within the most expensive 1% of beneficiaries, almost 83% have three or more chronic conditions, and more than 60% have five or more.

CHCS also provides a breakdown of the most common diagnostic pairs (or sets of diseases) experienced by the nation's highest-cost Medicaid beneficiaries. CHCS indicates that identifying the most commonly occurring co-morbidities within Medicaid's costliest beneficiaries may serve as a viable option for identifying those who might benefit from care management strategies (Center for Health Care Strategies Inc, March 2008). The medical home model of care in Kansas is anticipated to incorporate this kind of coordinated care management.

Top 10 Diagnostic Pairs Among the Most Costly 5% of Medicaid Beneficiaries

Diagnostic Pair	Percent of most costly 5% diagnosed with this pair
Cardiovascular-Pulmonary	30.5%
Cardiovascular-Gastrointestinal	24.8%
Cardiovascular-Central Nervous System	24.8%
Central Nervous System-Pulmonary	23.8%
Pulmonary-Gastrointestinal	23.8%
Cardiovascular-Psychiatric	22.0%
Cardiovascular-Renal	20.8%
Central Nervous System-Gastrointestinal	20.7%
Psychiatric-Central Nervous System	20.7%
Cardiovascular-Diabetes	19.2%

Source: *The Faces of Medicaid II: Recognizing the Care Needs of People with Multiple Chronic Conditions. Center for Health Care Strategies, Inc., October 2007.*

These findings from national analyses illustrate the complex nature of health and disease in Medicaid's costliest populations, and help explain why health management strategies for the populations lag behind the expansion of managed care for children and younger, healthier families.

The Aged and Disabled (AD) Population in Kansas

Although Kansas is not currently participating in a CHCS sponsored initiative, a recently awarded CMS transformation grant has funded a project which will examine the characteristics of the Kansas aged and disabled populations. Theresa Shireman, PhD from the University of Kansas Medical Center, has recently completed a preliminary analysis of Kansas data using an Ingenix Impact-Pro tool. Baseline data includes all of the Medicaid beneficiaries in the eligibility groups previously described, from September 1, 2006 through August 31, 2007. Demographic and quality of care measures are presented in the tables below.

Table 2
Descriptive Characteristics of Aged and Disabled enrollees: September 2007- August 2008

Demographics	Enrollment	Percent
	N = 82,849	
Female	47,732	57.9
Caucasian	66,856	81.0
African-American	11,454	13.9
Hispanic	4,343	5.3
Age, mean in years (range)	52.0 (0-107)	
Chronic Conditions (Clinical Indicator)		
Diabetes	12,727	15.4
Depression	7,524	9.1
Hypertension	13,018	15.8
Congestive heart failure	3,031	3.7
Coronary artery disease	2,880	3.5
Asthma	2,247	2.7

Quality of Care

The Impact-Pro tools identifies instances when beneficiaries need to have preventive age and gender appropriate screenings (e.g., mammograms, colonoscopies) or monitoring procedures for chronic conditions. All of the 82,849 beneficiaries described above had at least one missed care opportunity. Care opportunity rates for various chronic conditions are presented below.

Table 3
Care Opportunity Rates for Aged and Disabled Enrollees with Diabetes

	Number Enrolled N= 12,727
Care Opportunity Description	
Blood glucose monitoring:	
No evidence of HbA1c testing in 12 months	53.5%
Follow-up care & monitoring of other lab values:	
No evidence of lipid testing	68.8%
No evidence of visit to eye specialist	73.9%

Table 4
Care opportunity rates for Aged and Disabled Enrollees with Depression

	Number Enrolled N= 7,524
Care Opportunity Description	
No follow-up to the initiation of prescription therapy	7.3%

Table 5
Care Opportunity Rates for Aged and Disabled Enrollees with Coronary Artery Disease (CAD)

	Number Enrolled N= 2,880
Care Opportunity Description	
No evidence of lipid testing	71.1%
No lipid lowering medication	28.6%

Table 6
Care Opportunity Rates for Aged and Disabled Enrollees with Hypertension

	Number Enrolled N= 13,018
Care Opportunity Description	
No evidence of diuretics while on other hypertension drugs	24.3%

Table 7
Care opportunity rates for Aged and Disabled Enrollees with congestive heart failure (CHF)

	Number Enrolled N= 3,031
Care Opportunity Description	
Inadequate CHF pharmacotherapy	
No evidence of ACE inhibitors	41.1%
No beta-blocker	41.7%
No lipid lowering therapy	41.2%

Table 8
Care opportunity rates for Aged and Disabled Enrollees with asthma

	Number Enrolled N = 2,247
Care Opportunity Description	
Medication related issues:	
No evidence of inhaled steroids for asthma	57.9%
Asthma-related health care use:	
No evidence of primary care visit in recent 6 months	67.9%

Table 9
Miscellaneous Preventive Care Opportunities for Aged and Disabled

Care Opportunity Type	Population	Aged and Disabled Enrollees
Cancer Screening		
No evidence of breast cancer screening	Females, ages 40 up to 65 years	N = 17,569
		73.9%
No evidence of cervical cancer screening	Females, ages 18 up to 65 years	N = 24,323
		78.9%
No evidence of colorectal cancer screening	Males & females, ages 50 up to 65 years	N = 18,981
		76.5%
Cardiac Event Prevention		
No evidence lipid testing: adults	Males & females, ages 40 +	58,395
		82.6%
No evidence of lipid testing: atypical antipsychotic users	Males & females, ages 18 +: min 3 Rxs for atypical	7,287
		79.5%
Osteoporosis Screening		
No evidence of osteoporosis screening	Females, ages 50 +	N = 31,094
		95.4%
Pain management		
Prolonged opioid use, pain management referral indicated	Adults, 18 +	N = 72,519
		8.7%

Limitations

There are several limitations to using Medicaid claims data and the Impact Pro tool. These limitations include using only one year's worth of claims data and not having access to the pharmacy claims for Medicare Part D beneficiaries. Because access to the claims data is limited to the most current one year period, preventive procedures that are only required on a periodic basis (e.g., a colonoscopy every 10 years) may not be reflected. Additionally, the absence of pharmacy claims for Medicare Part D beneficiaries does not allow the case managers to see what medications have

been dispensed and if associated problems or concerns exist. Most of the care opportunity flags associated with medication problems, however, indicate when a medication is not being used when it should (e.g., a person with hypertension not receiving a diuretic or an asthma patient without a rescue medication refill, etc.).

Despite these limitations, the data presented in Tables 2-9 indicate a quality of care issue among aged and disabled Medicaid beneficiaries, and suggest significant opportunities to help beneficiaries engage in preventive health care. The transformation grant described below is one such opportunity, but the patterns of care illustrated above suggest the need for continued innovation and focused attention to these populations. Properly designed, a medical home model could significantly improve the comprehensive care coordination needed for this population.

Kansas Projects

Kansas is currently implementing two pilot projects that aim to improve health outcomes for people with disabilities. These two projects are "Health Promotion for Kansans with Disabilities" and "Enhanced Care Management." A description of each follows.

Health Promotion for Kansans with Disabilities

As mentioned previously, the Kansas Health Policy Authority was awarded a CMS transformation grant in February 2007 to improve preventive health care for disabled Kansans enrolled in Medicaid. Integral to achieving the outcomes of the pilot project is the use of the Ingenix ImpactPro information technology tool which allows case managers and independent living counselors to review the history of and the need for preventive health care for adult beneficiaries. Specifically, the tool uses Medicaid claims data to "flag" instances when beneficiaries need to have best practice preventive age and gender appropriate screenings (e.g., mammograms, colonoscopies) or other monitoring for chronic conditions. Once the preventive health care opportunities have been identified, case managers and independent living counselors can discuss with beneficiaries and their health care providers the importance and necessity of recommended screenings and monitoring. The overall goal of the project is to improve the provision of quality preventive health care services and quality monitoring for chronic conditions.

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

Enhanced Care Management

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

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

> "In a Medicaid population, chronic conditions cannot be managed without considering the *whole person*; the co-morbidities, the mental health of recipients and social conditions that would otherwise prevent one from achieving effective self-care."
>
> Source: *Making Medicaid Work: A Practical Guide for Transforming Medicaid* (co-authored by SHPS represented by Rishabh Mehrotra, President and CEO, and the Center for Health Transformation represented by Founder Newt Gin-

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

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

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

As of August 31, 2007, there were 154 beneficiaries enrolled in the program. An internal analysis of the ECM program prepared by the Central Plains Regional Health Care Foundation, analyzing all active clients and clients enrolled since March 1, 2007, yielded the following results:

- The ECM population was predominantly female (69.0%) aged 41 to 64 years (73.2%), and single, divorced or widowed (83.5%).
- The race/ethnicity of participants was White-Non-Hispanic, (48.3%), followed by African American (28.7%), White-Hispanic (7.7%), Asian/Pacific Islander (2.3%) and Native American (3.1%).
- Nearly 80% of the beneficiaries reported a high school education or less (78.1%), and more than 90.0% reported an income of less than $1,000 per month. Additionally, a large percentage of beneficiaries (67.5%) reported receiving food stamps.
- The recorded Body Mass Index (BMI) suggests that the majority of enrolled clients are overweight or obese.
- The mean and median number of state identified chronic conditions per client was 2.8 and 3.0, respectively. However, 32 clients had four conditions, 33 had five conditions, and 24 had six

conditions.

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

Steps **B**eing **T**aken by **O**ther **S**tates

Recently, substantial attention has been focused on how states can better meet the complex needs of people with disabilities. A growing number of states have begun exploring or implementing models of managing care for populations with complex health care needs. Because people with disabilities often experience multiple chronic conditions, models of managed care include traditional full-risk capitation, as well as broader or more inclusive models such as enhanced primary care case management and comprehensive care management. Increasingly, states are moving from single disease management approaches in which only particular diseases are covered one at a time (e.g., diabetes, asthma, congestive heart failure), and instead are focusing on strategies needed to assess and treat people with multiple chronic conditions; this trend underscores the interest and need for the development of the medical home model.

During November 2006, CHCS interviewed staff in 14 selected states to provide a nationwide scan of the current status of Medicaid managed care. The states selected represent variation in Medicaid delivery across the United States, however, all either had a managed care program for their aged and disabled population in place, or had plans to implement an expansion or pilot a program. States included in the scan were: California, Colorado, Florida, Georgia, Hawaii, Kentucky, Maryland, Michigan, Ohio, Oregon, Pennsylvania, Texas, Washington, and Wisconsin. In addition to these states, there are others such as North Carolina and Indiana that have implemented managed care programs for the Aged and Disabled (AD) and have been cited as being particularly successful and promising. A brief description of these two programs is presented below. Pennsylvania's program is also described in order to provide an example of a more traditional style managed care program offered to the aged and disabled.

North Carolina

North Carolina uses one type of medical-home model that aims to strengthen the connection between Medicaid beneficiaries with complex needs and their providers. Its program, Community Care of North Carolina (CCNC) is an Enhanced Primary Care Case Management Model (EPCCM) program that provides an enhanced level of services to its target high-risk population. It enrolls approximately 35% of the AD/SSI population and includes core care management strategies such as risk assessment, emergency room utilization, disease specific case management, and pharmaceutical management (Bella, Shearer, Llanos, Somers, 2008). Fourteen Community Care networks, consisting of 3,000 physicians and numerous community support services, provide these care management services (Bella et al, 2008). Also being piloted is a Chronic Care Project, which is designed to serve North Carolina's highest-risk, highest cost AD/SSI beneficiaries.

Indiana

Indiana Care Select is geared towards improving the quality of care provided to AD beneficiaries, including those receiving services through HCBS waivers. The program, which provides services through two care management organizations (CMOs), was implemented in November 2007 with statewide implementation planned for March 2008. Care Select uses a health assessment screener combined with claims data to identify and prioritize the care requirements of newly enrolled beneficiaries (CHCS, March 2008). Beneficiaries are then stratified into four groups based on the severity of their needs; corresponding care management strategies are then made available based on risk level and needs. One of the unique features of Indiana's program is the pay-for-performance strategies used: CMO incentive payments and withholds are implemented based on the timeliness and submission rate of the health assessments in addition to increased payments to providers who adopt identified best practices (CHCS, March 2008). Prevention Quality Indicators (PQIs), developed by the Agency for Healthcare Research, are used to measure care management quality. PQIs capture data on hospital admission rates for conditions such as dehydration, bacterial pneumonia, etc. that are common to people with chronic illnesses but that are recognized as avoidable or preventable if proper care management has been provided (CHCS, March 2008).

Pennsylvania

The HealthChoices Program is a mandatory managed care program, authorized through a 1915(b) waiver, for Medicaid consumers in Pennsylvania. As noted in their program description, the impetus for development of this program was "recognition of a national trend that the Fee-For-Service health care delivery system was neither cost effective nor delivered care with assurance for quality and access"(Health Choices Physical Health Update, 2008). Along with beneficiaries of all age groups and most eligibility groups, the aged and disabled are included in the program. Beneficiaries receive services through two types of Managed Care Organizations (MCOs) health plans. Physical health plans provide and/or authorize physical health services while behavioral health MCOs are responsible for providing and/or authorizing mental health and drug and alcohol services. Currently the program is operational in 25 counties.

Conclusions

- Aged and disabled beneficiaries are driving the costs of the Kansas Medicaid program. They account for only 33% of the Medicaid population, but in FY 2008 were responsible for approximately 67% of the total expenditures for Medicaid when long-term care costs were included.
- The percentage of growth attributed to the aged and disabled when compared to all other populations was a combined 46.6% (i.e., 6% of the growth was attributed to the aged while 40.6% was attributed to the disabled) from FY 2007 to FY 2009.
- Unlike lower-cost populations, health care for the aged and disabled is not adequately managed. Moreover, significant quality of care issues exist, as illustrated in tables 2-9.
- Continuation and more complete evaluation of both of the KHPA pilot projects (i.e., Health Promotion for Kansans with Disabilities and Enhanced Care Management of Sedgwick County) is needed to determine how to make program improvements before statewide implementation is considered. A budget proposal to extend the Health Promotion for Kansans with Disabilities pilot was presented and approved by the KHPA Board on August 19, 2008. If approved by the Legislature, the proposal will provide care management information to

providers across Kansas who serve elderly and Medicaid eligible persons with disabilities.

- Steps are currently being taken by other states to examine ways that coordinated comprehensive care can be used to provide better and more cost effective care to the aged and disabled. Kansas can benefit from the lessons learned by other states.

Recommendations

1. Utilize existing information from the KHPA pilot projects and other states to effectively design, implement, and evaluate managed care programs for people with disabilities. Guidelines that have been developed, based on other states' experience, include:

    a. The necessity of consumer support and involvement in the development, design, implementation and oversight of the program.
    b. Careful identification of the target population (e.g., will the program target high-risk, high-cost individuals? Individuals with specific diseases? Who are the consumers who will benefit most?)
    c. Designing the intervention to ensure services are multi-faceted, improves quality and cost effectiveness, and ensures coordination of care.
    d. Evaluation of the program should include methods for measuring whether or not the interventions are improving quality, efficiency, and effectiveness.
    e. Designing payment reforms that allow both the beneficiary and provider to be incentivized (e.g., case management/medical home payments, etc.)

2. Develop an FY 2011 budget proposal to include payment reforms for a medical home model for Kansas, to include care for the aged and disabled. The development of a medical home model for Kansas is currently underway with the passage of Senate Bill 81 during the 2008 legislative session. A large group of stakeholders will design over the next year a care management model based on existing evidence and the needs of our state. The recommendations will be brought to the KHPA Board in 2009 for consideration in development of the FY 2011 budget.

3. Provide care management information to service providers across Kansas that serve aged and Medicaid eligible persons with disabilities by continuing the model tested through the CMS Transformation Grant "Health Promotion for Kansans with Disabilities." If approved by the legislature, this project would use the experience gained during the pilot project and expand the program intervention to all aged and disabled Medicaid beneficiaries statewide. Specific quality of care topics would be selected monthly by KHPA and used to query Medicaid claims information, supplemented by other data sets from Medicaid services administered by the Department of Social and Rehabilitation Services. Outreach information on those topics would be targeted to beneficiaries, primary care physicians, pharmacists, and other regular sources of health care. The risk modeling effort also would be continued to identify population groups and subgroups that would benefit from targeted interventions.

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