

Presentation to:

**Medicaid Oversight Committee  
Commonwealth of Kentucky**

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**Cabinet for Health and Family Services**

Mr. Chairman, thank you for the invitation to testify to your committee. For the past three and a half years I've worked diligently to modernize Kentucky's Medicaid program into a 21<sup>st</sup> Century health model. I'd like to take this opportunity to review where we started, outline our tactical approach to modernizing the Medicaid program, and share with you data that proves our efforts are working.

In February of 2004, soon after I was appointed by the Governor to take lead on his health care programs, I sat in front of many of you to share our Medicaid budget situation. Like many of the surrounding states, Kentucky's Medicaid expenditures were forecasted well over its budget. It was bleeding red. Other states and the previous administration attempted to solve this problem by kicking elder Medicaid members out of nursing homes by reducing eligibility and services. I thought we could do better by the folks we are appointed to serve.

The administrative infrastructure was just as obsolete as the policy making. Medicaid's claims payment system was the same one from the mid-80s and we were mailing out paper ID cards monthly.

As compared to private insurance, Medicaid's mix of brand versus generic was backwards and we had instances of members receiving over 25 prescriptions. And worst of all, we were forced to hear anecdotal stories of Medicaid's utilization because there was limited reporting available in our outdated systems.

I had just finished a stint as the chief executive officer for a mid-sized health insurer and knew the opportunities to modernize in Kentucky were unlimited. Immediately I set off to transform the infrastructure and culture. Old Medicaid was "see the claim, pay the claim." New Medicaid would move Kentucky from an illness model to a "wellness model." Old Medicaid kept the other government programs and the private sector at arms length. New Medicaid would embrace partnerships with mental health, public health and their local health departments, and bring in the private sector to rejuvenate our systems and encourage creative out-of-the-box thinking. Old Medicaid was "one size fits all." New Medicaid would have tailored benefits and encourage consumers to engage in their health care decisions.

**Introducing "KyHealth Choices"**

Kentucky's new health care team envisioned a Medicaid program that would:

- ◆ Improve the health status of those Kentuckians enrolled in the program;
- ◆ Ensure people receive the right care, in the right setting, at the right time; and
- ◆ Ensure the solvency of Kentucky Medicaid for future generations of Kentuckians.

I sound like a broken record, but I believe that Medicaid modernization is like a three-legged stool. The three legs are:

- Technology & Infrastructure
- Benefit Design
- Care Management

If any of these three legs failed, our reform efforts would wobble. We also politically only had a limited amount of time to prove that our tactical approaches could work in a mostly rural state such as Kentucky.

## **I. Technology & Infrastructure**

Like everyone who deals in state procurement, we set about in to release several request for proposals from the private sector. We procured:

Kentucky Medicaid Management Information System (MMIS) for improved claims and administrative infrastructure (we're told by our partners EDS and SHPS that ours is the most sophisticated MMIS in the U.S.) This contract includes:

- Intequal © Utilization Management (Medical Management Criteria)
- Web Based Interface for Providers
- Real Time Claims Adjudication
- Real Time Prior Authorization
- Real Time Eligibility Verification
- 24/7 Systems Access

Kentucky Medicaid Administration Agent (KMAA) for better care management. This contract includes:

- Customer Service
- Nurse 411 Member Call Line
- Disease Management
- Credentialing

Kentucky Pharmacy Benefit Administrator (PBA) to better manage our most expensive benefit, increase rebates to Kentucky, and implement our three-tiered formulary.

## **II. Benefit Design**

With the support of the state legislature, both through a joint resolution and administrative regulations, we established four separate KyHealth Choices Benefit Plans:

- Global Choices:
  - General Medicaid Population – 235,000
- Optimum Choices:
  - ICF/MR Level of Care – 3,500
- Comprehensive Choices:
  - NF Level of Care – 27,900
- Family Choices:
  - KCHIP and most children served in Medicaid – 263,000

Each of these KyHealth Choices plans is unique, but focus on core tactical changes in the Medicaid program:

- Cost sharing and alternative premiums
- New rules for prescription drug coverage
- Co-pays for emergency room visits for non-emergency care
- Increases in the use of home and community services rather than institutional, long-term care services
- Service limitations
- Maximum out-of-pocket expense limits to protect members
- Consumer involvement in prevention and care management

**I'm pleased to report that the implementation of these efforts has not diminished (and has in some cases improved) access to care.**

### **III. Care Management**

In Kentucky, just as on the national level, we spend an inordinate amount (\$2 billion) on just a few conditions:

- Diabetes
- COPD
- Asthma
- Heart disease, stroke/TIA and heart failure
- Neo-natal babies

Chronic illness accounts for 74% of all total medical spending. After including all behavioral health issues, this increases to 82% of total medical spending. For any state, this is unsustainable.

My goal with our care management initiatives is to break down institutional barriers in order to connect members with chronic illness with health care services and demonstrate improvement in health status of our Medicaid members.

Disease management is a term lots of folks in the private sector have throw around since the 1990s. And a lot of money has been thrown at disease management, a shotgun approach, with limited return.

So in Kentucky, we launched disease management pilot programs in counties with high risk for specific diseases. So instead of immediately launching a statewide diabetes

case management program, we worked with the legislature to fund six diabetes “Centers of Excellence” in counties with the highest prevalence of this disease. Additionally, we launched county-specific programs for:

- Pediatric Asthma and COPD / Adult Asthma
- Pediatric and Adult Obesity
- Cardiac and Coronary Artery Disease
- Breast and Cervical Cancer
- Prostate Cancer Screening
- Minority Health
- Pediatric Diabetes
- Osteoporosis

One Medicaid member recently told a disease management program nurse, “I have learned more in two weeks about my diabetes from the DM program, than I learned in two years from my doctor.”

### **D.R.A. Flexibility**

As many of you know, we initially sought flexibility from CMS to tailor benefits in Medicaid through the development of a “mega-waiver.” With passage of the much-heralded Deficit Reduction Act in 2005, states were afforded a great deal of flexibility without having to seek federal waivers. Additionally, waivers typically bring with them the drawback of budget neutrality or capped grants.

Here in Kentucky, we quickly acted upon these federal changes and were the first state in the country whose state plan was approved to use newfound flexibility. But we wanted to do so responsibly, engaging our advocacy community to help build our strategic vision for best serving all populations eligible for Medicaid. Advocates quickly convinced us that our greatest opportunity in policy making lay in meeting head-on the aging of the baby boomer population.

In the fall of 2006 I proposed, the Governor signed, and the legislature ratified the creation of a new Department for Aging & Independent Living. For the first time, policy making across the administration for elder Kentuckians and Kentuckians with disabilities became housed in one location. The department launched soon after our “**Long Term Living Initiative.**”

Its vision is to use new flexibility in Medicaid to redesign long term care services and programs in both the public and private sector to enable easy consumer access, a full continuum of services to match consumer needs, and delivery of quality services in a timely manner. And the Long Term Living Advisory body has been composed of providers, consumers, family members and advocacy organizations.

## Long-Term Living Initiatives

Let me quickly go through our top long term living initiatives, all of which signify ongoing efforts to break down tradition silos within state government:

- ◆ KyHealth Choices and Long-Term Living Initiatives are helping Kentuckians with Medicaid direct and manage their personal assistance services according to their own specific needs.
- ◆ The **Consumer Directed Option (CDO)** program is providing consumers the option to control their non-medical services (House Bill 116) to stay in their homes and communities. (Rep. Jimmie Lee)
- ◆ **Money Follows the Person (MFP)** eliminates barriers that prevent or restrict the flexible use of Medicaid funds to enable individuals in institutions to receive support for appropriate and necessary long-term services in the settings of their choice. Kentucky awarded a \$50 million, five-year grant from CMS in May 2007.
- ◆ **Self-Directed Option (SDO) Pilot** will give even greater freedom to individuals to direct their own care. (Pilot targets 200 individuals.)
- ◆ **The Kentucky Resource Market** provides information by phone about available local and statewide programs and services, and referrals to community resources to meet individual needs.

## Medicaid and e-Health

Another by-product resulting from our “base of reformation” is that Kentucky received a \$4.9 million transformation grant from CMS over 2 years to support initial development of the Kentucky Health Information Partnership (K-HIP). K-HIP is a Medicaid-led alliance of payors working together to develop statewide health information exchange:

- A statewide Web-based portal;
- Electronic access to a patient health summary based initially on claims data (drug history, ER visits, etc.); and
- Single-sign on access for electronic administrative transactions (eligibility check, claims, prior authorization).

## Signs Kentucky’s Efforts are Working

Let me conclude with proof our efforts are working and the three-legged stool is balanced. First and foremost, our Medicaid budget has balanced without reducing enrollment or harming access to care.

The number of uninsured is down in Kentucky and employer-sponsored health insurance is up according to Kaiser Family Foundation.

And our new approach is allowing us to attract and leverage external funding to help Kentucky fundamentally transform systems and services.

## **KyHealth Choices**

- ◆ Eliminates the one-size fits all approach to Medicaid
- ◆ Is transforming Medicaid into a 21<sup>st</sup> Century health plan
- ◆ Empowers members to be active participants in their own health care
- ◆ Improves wellness and quality of care delivered to our members
- ◆ Enables the Commonwealth to break down the silos that hinder true coordination of care and services
- ◆ Improves the long-term solvency of this vital program
- ◆ Encourages better health status for members

**Signs Kentucky's Efforts are Working – Cost per Member per Week:**

- ◆ July 2005 to January 2006:
  - Enrollees -- 696,779
  - Cost per Member per Week -- \$119.09
  - Weekly Cycle Cost -- \$82,982,370
- ◆ July 2006 to January 2007:
  - Enrollees – 709,384
  - Cost per Member per Week -- \$115.04
  - Weekly Cycle Cost -- \$81,604,061

**Signs Kentucky's Efforts are Working – Average Inpatient Length of Stay:**

- ◆ October 2005 to March 2006 – 4.6
- ◆ October 2006 to March 2007 – 3.2

**Signs Kentucky's Efforts are Working – Inpatient Cost per Claim:**

- ◆ October 2005 to March 2006 – \$3,952.07
- ◆ October 2006 to March 2007 – \$3,212.41

**Signs Kentucky's Efforts are working – Monthly Pharmacy Claims:**

- ◆ October 2005 to March 2006:
  - Brand: 347,205
  - Generic: 522,990
- ◆ October 2006 to March 2007:
  - Brand: 32,949
  - Generic: 543,581
- ◆ Drug Rebates:
  - FY2003 was \$118 million
  - FY2006 was \$216 million
- ◆ Average Rx per person is down from 5.2 to 3.6
- ◆ Since December 2005 cost per claim has dropped 4.75% cost per claim
- ◆ Generic usage is now 62%

**Signs Kentucky's Efforts are Working – Disease Management, Case Management Accomplishments, for enrollees in diabetes program in 1 year:**

- ◆ 62% of program participants with baseline HbgA1c level lowered their HbgA1c levels toward 7%
- ◆ 92.5% of program members ages 18 to 75 continuously enrolled for 12 months received HbgA1c testing
- ◆ Program participants demonstrated 75.6% improvement from their first LDL-C screening to their follow up LDL-C
- ◆ Program participants demonstrated a 50% increase in monitoring for complications of kidney functioning
- ◆ Program participants demonstrated an 80.5% increase in eye exams
- ◆ Program participant ER visits were reduced by 7.5%