Approved: 02/12/09
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman Jim Barnett at 1:30 p.m. on January 20, 2009, in Room 136-N of the Capitol.

Senator David Haley was excused.

Committee staff present:
Nobuko Folmsbee, Office of the Revisor of Statutes
Doug Taylor, Office of the Revisor of Statutes
Kelly Navinsky-Wenzl, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Jan Lunn, Committee Assistant

Conferees appearing before the committee:
John Miall, Special Consultant to the American Pharmacists Association for HealthMapRx
Ben Bluml, Senior Vice President for Clinical Outcomes, American Pharmacists Association
Barb Langner, PhD, Policy Director, Kansas Health Policy Authority

Others attending:
Approximately 22 members of the public

Chairman Barnett recognized Ron Hein, representing the Kansas Restaurant and Hospitality Association and Reynolds American, Inc., who requested introduction of a bill dealing with the subject of a statewide smoking ban. The bill would recognize accommodation for both smokers and non-smokers. Upon a motion by Senator Barnett for introduction of this legislation and a second by Senator Pilcher-Cook; the motion passed.

Senator Vicki Schmidt moved introduction of a bill relating to TB evaluation requirements. Senator Brungardt seconded the motion; the motion passed.

Senator Vicki Schmidt moved introduction of a bill concerning polysomnographic technologists; Senator Brungardt seconded the motion. The motion passed unanimously.

Senator Schmidt introduced John Miall and Ben Bluml, from HealthMapRx (better known as the Asheville Project). Senator Schmidt indicated that as focus on saving healthcare dollars has escalated, the Asheville Project has been considered a "success story" in North Carolina and throughout the United States.

Mr. Miall indicated the Asheville Project was born from a frustration stemming from containing healthcare costs in Asheville, North Carolina. It is a patient-centered model involving collaboration among nurses, pharmacists, physicians, and other health care providers. Mr. Miall outlined the project which focuses on chronic diseases (diabetes, cardiovascular, and asthma,) and interventions by pharmacists (as the hub or point of care) collaborating and coordinating with other healthcare providers to achieve optimum outcomes for patients (Attachment 1). He reported that following implementation, the City of Asheville's savings has been greater than $6 million in eight years. Mr. Miall indicated that currently there are 100 locations around the U.S. that have implemented this model. Pharmacists are provided additional training and perform as the regular point of patient contact. All data is transmitted back to the primary care provider to ensure continuity of care. The pharmacist is paid a fee for each patient contact.

Mr. Miall indicated efficacy of the program has been documented and that following a meeting with leaders at the KU School of Pharmacy, a pilot program is proposed for four areas in Kansas: Topeka, Wichita, Kansas City metro, and Lawrence. It is believed positive results can be realized after one year. Data collection and analyzation will take approximately 6-12 month following the date of implementation.

Senator Kelly requested clarification related to cardiovascular events and the number of patients in medication compliance (Statin therapy) three years prior to and three years after program implementation. Mr. Bluml agreed that the percentage of those in compliance pre-program is unknown and following implementation, compliance is known by refill data.

Senator Kelsey inquired as who pays the pharmacist and how much the pharmacist is paid. Mr. Miall and Mr.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

Minutes of the Senate Public Health And Welfare Committee at 1:30 p.m. on January 20, 2009, in Room 136-N of the Capitol.

Bluml reported there are several methods in which a pharmacist is paid: by third party administrator, a health plan benefit manager, or a small for-profit business that provides that service. Fees are negotiated in each community across the United States. Mr. Bluml indicated an average fee is $2-$3 per minute per face-to-face contact. The projections made during the presentation were based on a pharmacist rate of $2.50 per minute with typical utilization patterns for each diagnosis.

Senator Kelly asked if the pharmacist reimbursement was based on time spent during a patient encounter and if so, what safeguards are included in the program to ensure accurate billing. Mr. Miall clarified that each pharmacist documents his/her clinical services and the amount of time spent in each encounter which is considered the pharmacist's attestation and therefore, is the basis of the amount billed to the health plan.

Senator Barnett recognized Barb Langner, PhD, policy director of the Kansas Health Policy Authority, who presented information (Attachment 2) on the Chronic Disease Management Initiative. Ms Langer reported various initiatives include:

a.) CMS Health Promotion Grant for Disabled
b.) Enhanced Care Management Pilot in Wichita
c.) State Employee Health Plan and Dialog Initiative
d.) Medical Home Initiative

Ms. Langer reported that Kansas was awarded $900,00 in January 2008 as part of a $150 million Medicaid Transformation Grant (MTG). Preliminary findings from the MTG show significant opportunities exist to help beneficiaries with preventive care, particularly for those struggling with chronic disease as well as opportunities for various health screens and disease prevention.

The Enhanced Care Management (ECM) project was designed to provide care management services to HealthConnect beneficiaries living in Sedgwick County. Ms. Langner described te project's goals, demographics, and early results.

The various opportunities and incentives for health screens contained in the State Employee Health Plan were described. Senator Schmidt asked Ms. Langner to provide information about the cost of incentives paid to state employees for participating in health screens, the number of employees who were provided incentives, and the expense for one-on-one coaching by health providers. In other words, the total cost of all incentives and services provided to state employees. Ms. Langner will follow up with the information requested

The Medical Home Initiative was discussed, and goals were reviewed. Ms. Langner reported a meeting among key stakeholders occurred in September 2008 and resulted in the formation of three sub-groups to explore ideas for marketing the medical home in Kansas, to identify how medical home principles can be applied in Kansas, and to consider designs for potential pilot projects in Kansas.

Senator Barnett adjourned the meeting at 2:24pm. The next meeting will be held on January 21, 2009 at 1:30pm.

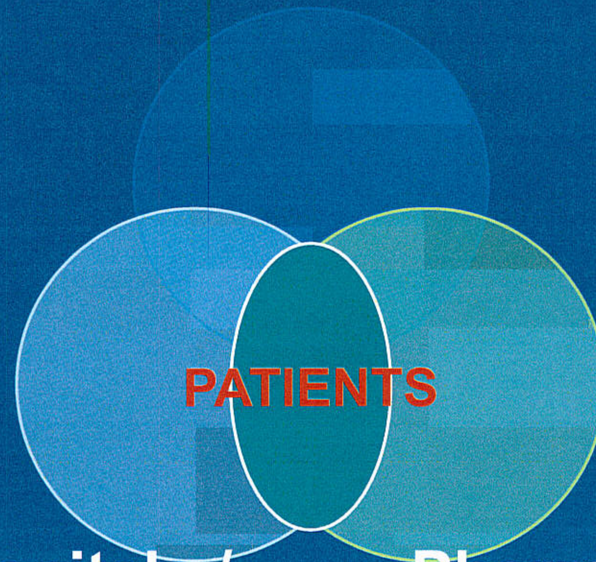
Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

Public Health & Welfare
1-20-09

| | |
|---|---|
| KEITH D. PANGBURN | KEARNEY & ASSOC. |
| Dustin Moyer | KHPA |
| Chris Gigstad | Federico Consulting |
| Nancy Zogleman | Polsinelli |
| Julie Hein | Hein Law Firm |

# HealthMapRx (Asheville)

Employers / Payers

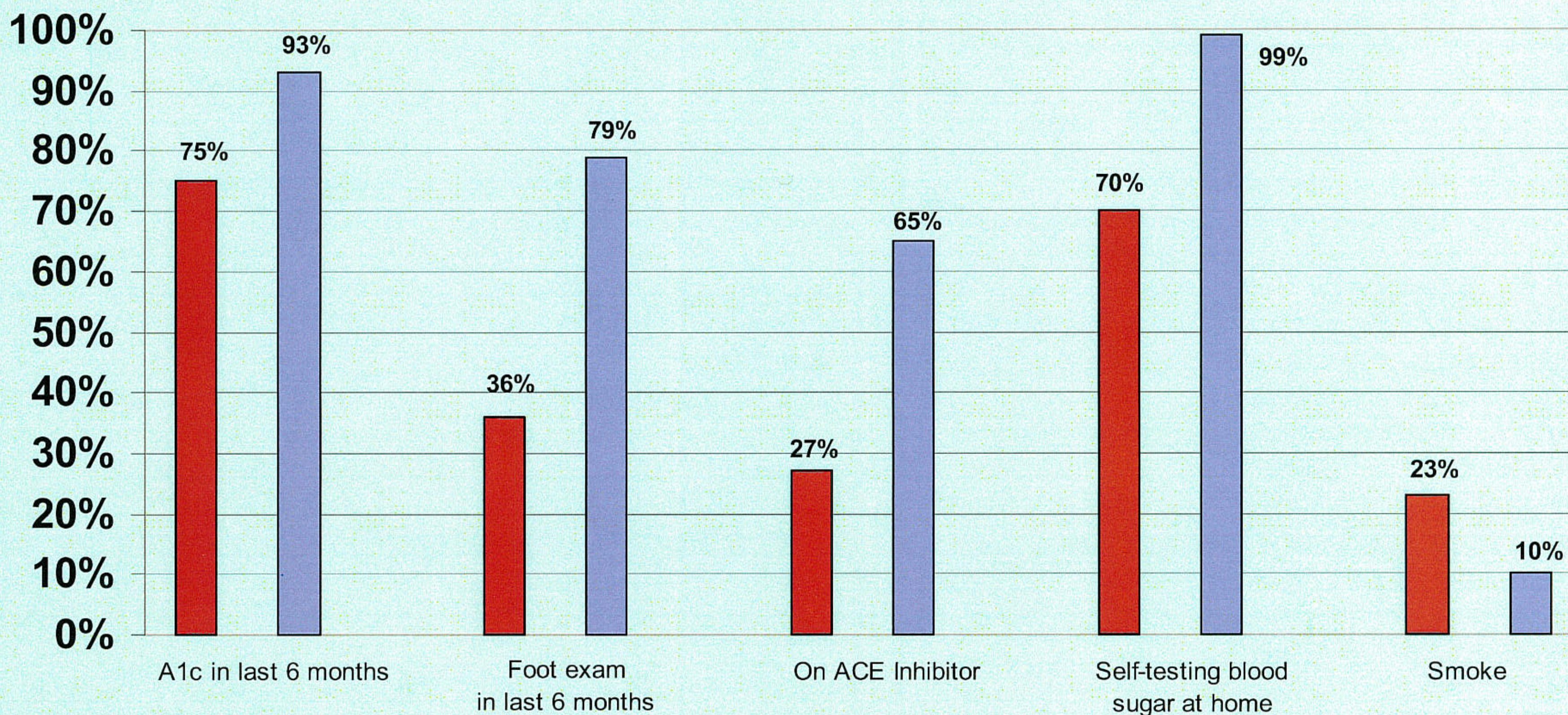



Physicians / Hospitals / Educators

Pharmacists / Pharma

Public Health and Welfare
Date: 01/20/09
Attachment: 1

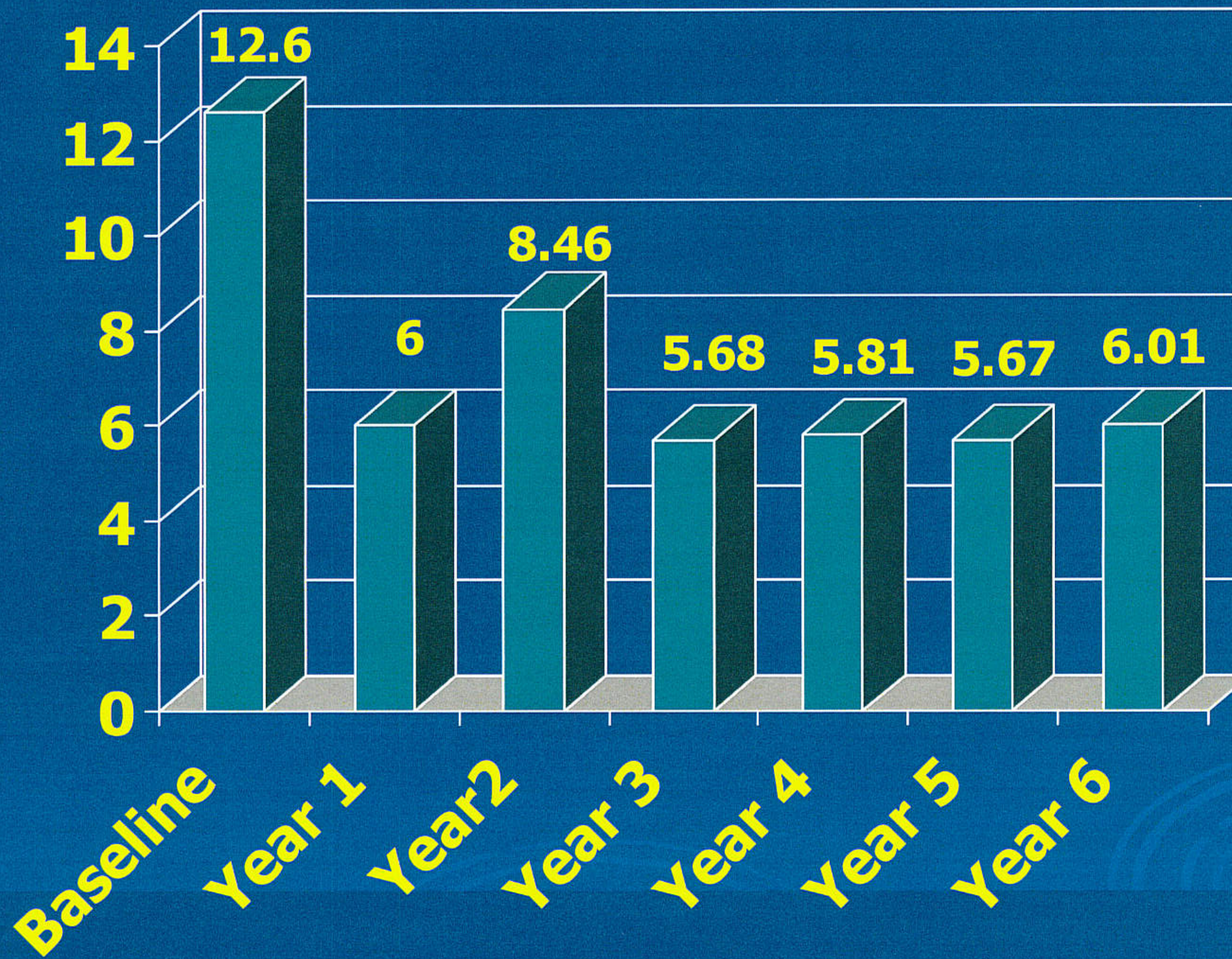
# Outcomes: Patient Goals (Asheville Diabetes Patients)




1-2

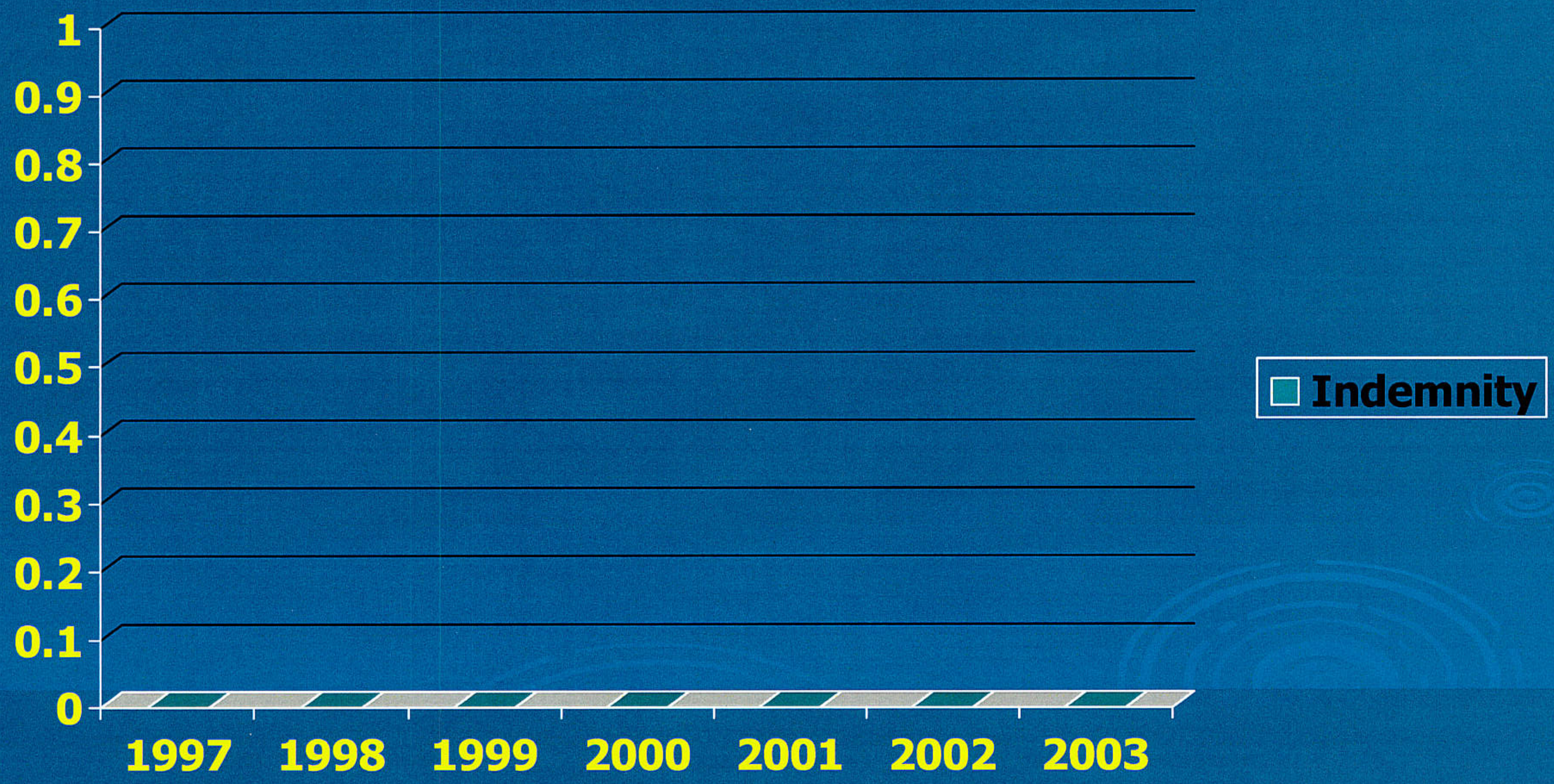
# Average Annual Diabetic Sick-Leave Usage

## (City Of Asheville)

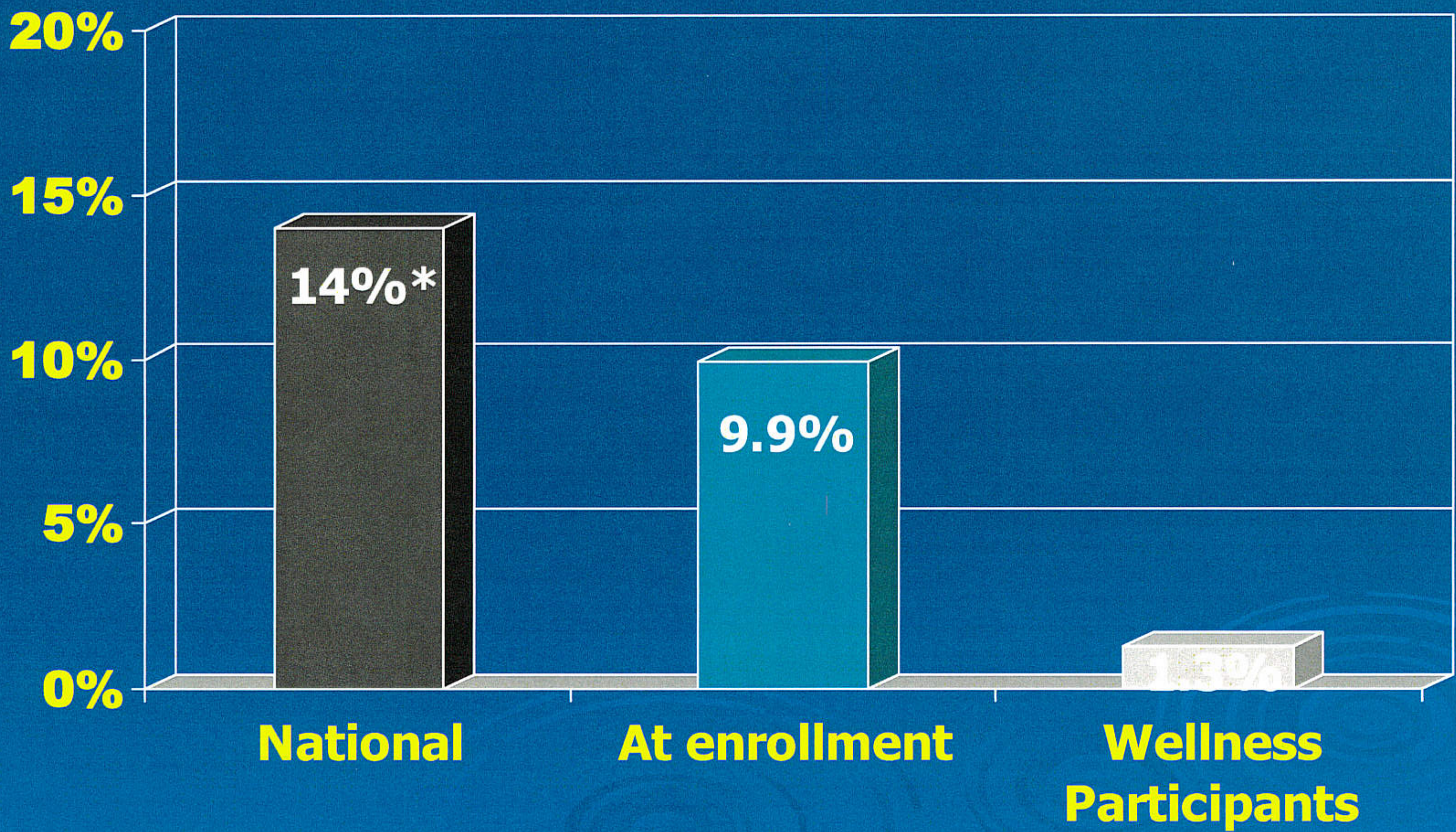


# DIABETES MANAGEMENT INDEMNITY CASES

## (City Of Asheville)

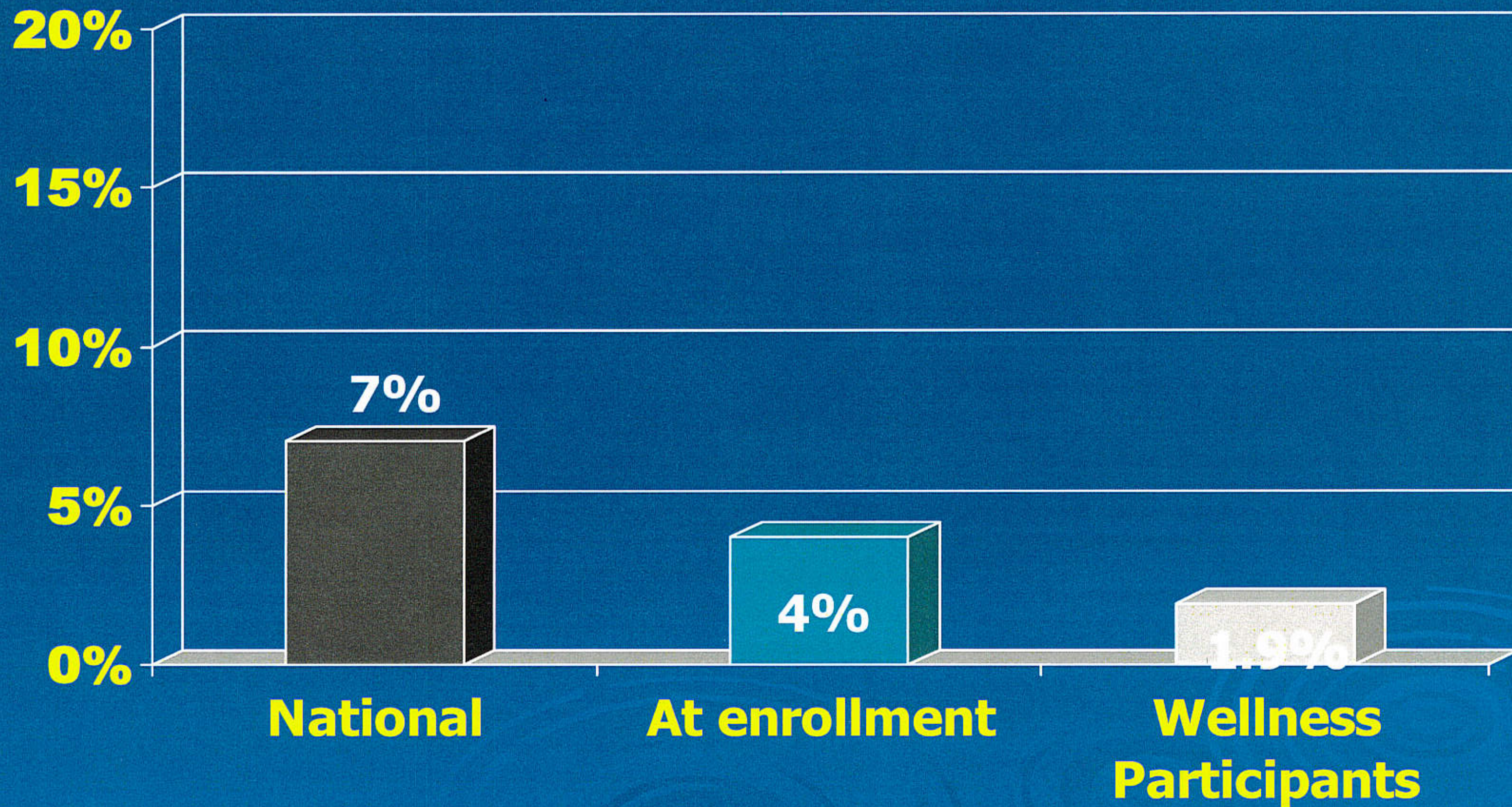


# Asthma
# Program patients with ED visits

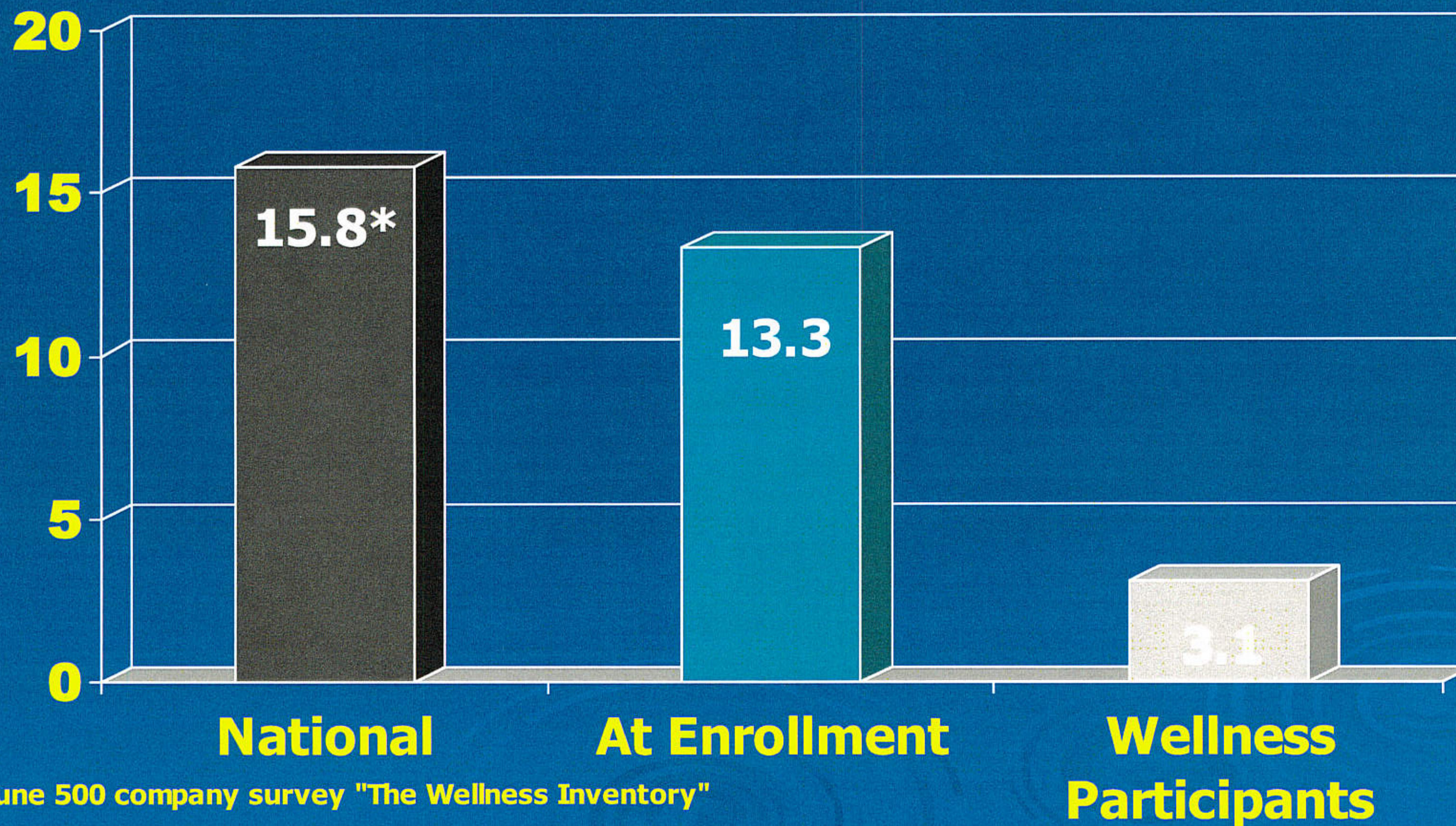



*Acordia data 2.2 million lives

# Asthma
# Program patients with Hospitalization



# Asthma
# Missed/Non-Productive Days/Year



# Cardiovascular events thru 2006

| Diseases | 3 years prior to program | 3 years after start of program |
|---|---|---|
| All cardiovascular events heart attacks/strokes/mini-strokes/acute angina | 93 | 50 |
| Heart Attacks | 23 | 6 |
| ER visits / Hospital Admissions | 175 | 81 |
| # of patients w/ 2 or more events per year | 13 | 2 |
| in compliance | - | 300% |
| Cardiovascular as a % of total client claims | 30.6% | 19.0% |
| Total cost of all events | $1,345,000 | $497,000 |

# Summary of Asheville Project Economic Outcomes

- *Net* decrease in total health care costs avg. >$2000/pt/yr (diabetes)
- *Net* decrease in total health care costs avg. $ 725/pt/yr (asthma)
- Diabetes: missed work hours decreased by 50%
- Asthma: missed work hours decreased by 400%
- ROI (calculated by employer, diabetes) of 4:1
- CV event rate (77/1000 person-years) was decreased to almost half (38/1000 person-years) in the study period.
  Average cost/event historical vs. study period was $14,343 vs. $9,931
- *Mission's total health plan costs rose 0.1% in 2004, and decreased by 1% in 2005, and decreased 3% in 2006.*

*The City of Asheville's plan costs for 2005 through 2008 were: 0%, 0%, -2.6%, and 0%*

- Mission & City of Asheville have saved >$6 million in 8 yrs

1-9

# APhA Foundation Patient Care Programs Across the Country

**Sites 2007: 18**
**Employers: 80**
**Patients >2,000**

1-10

# Conclusions

- Pharmacists have had the opportunity to serve on the frontline of patient care, and have made a difference.
- Physicians with patients in the program have recognized the positive impact on care.
- Collaboration plus innovation leads to reduced healthcare costs. Ashevillesm.wmv
- Employers benefit by lowering or eliminating barriers to care.

1-11

# Next Step

**Meet with all interested parties to develop pilot scope and design**

- Key partners (KHPA, HealthMapRx, KU School of Pharmacy, Kansas Pharmacists Association)
- Pilot location(s)
- Participant maximum
- Length of pilot/start date
- Budget and savings estimates

1-13

## Baseline Variables

*These are variables that can be known with certainty at the inception of the program. Default values are based on HealthMapRx experience, but these should be changed when more accurate data is available.*

| Variable | Value | Note |
|---|---|---|
| Number of Employees and Covered Lives | 92,000 | |
| Prevalence of Diabetes | 5.6% | (1) |
| Average Number of RXs/month for a patient with diabetes | 2.5 | |
| Average Employer Cost/Rx | $50 | |
| Average Amount of Copay/Rx | $20 | |
| Average Baseline Medical Cost/Year for Diabetic Patient | $8,350 | (2) |
| Applicable Fee Structure | Employer | |

## Projected Variables

*These are variables that cannot be known with certainty at the inception of the program, because they relate to future performance. Default values are based on HealthMapRx experience with employers implementing the program.*

| Variable | Value | Note |
|---|---|---|
| Projected Annual Medical Inflation | 10.6% | (3) |
| Projected Annual Prescription Cost Inflation | 7.7% | (4) |

| | Year 1 | Year 2 | Year 3 |
|---|---|---|---|
| Enrollment Rates (as a % of diabetic patients) | 50% | 67% | 75% |
| Average Rx Claims/Year for Diabetic Patient Relative to Baseline | 160% | 213% | 207% |
| Average Medical Claims/Year for Diabetic Patient Relative to Baseline | 62% | 58% | 53% |
| Average Pharmacist Counseling Fees | $750 | $325 | $325 |

***Important:*** *While total pharmacist fee are future variables and cannot be predicted with certainty, each market has its own agreement with a pharmacist network that specifies rates to be paid to pharmacists. These projections are based on a pharamcist rate of $2.50 per minute and typical utilization patterns. Please contact your local HealthMapRx coordinator for more details.*

Once you have reviewed the variables above and made changes based on your company's experience and expectations, please click here to view results.

(1) "Economic Costs of Diabetes in the U.S. in 2007," published by the American Diabetes Association, estimates that 5.6% of the working age population (with an average age of 40) has been diagnosed with diabetes. Diabetes prevalence will increase in populations with a higher average age.

(2) The ADA report referenced in (1), above, states that people with diagnosed diabetes incur average health expenditures of $11,744 per year. Approximately 21% of these costs are related to medication and supplies, leaving a remainder of $9,277 as direct medical care. Of this amount, we estimate that employers pay 90%, yielding a direct medical cost to employers of $8,350 per diabetic patient.

(3) Default value of 10.6% based on report by Aon Consulting, August 12, 2008.

(4) Default value of 7.7% is based on data quoted by PhRMA.

© 2008 APhA Foundation. All Rights Reserved.

By viewing this page I have agreed to the terms defined at the start of this Savings Calculator [click here for details]

## RESULTS

Click here for a printable version of these results.

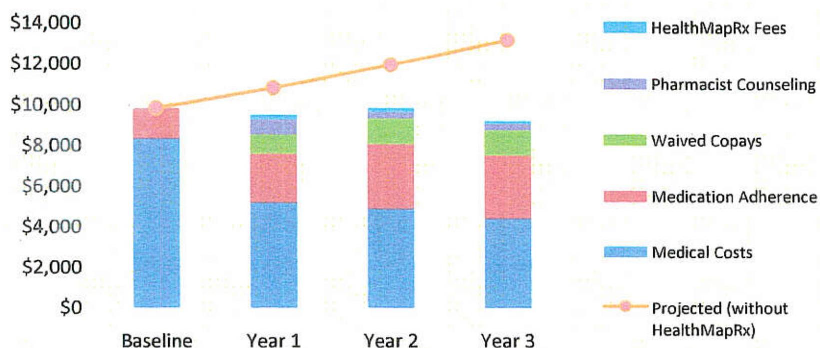
### Per Participating Patient

| | Baseline | Year 1 | Year 2 | Year 3 | TOTAL |
|---|---|---|---|---|---|
| Medical Costs | $8,350 | $5,197 | $4,880 | $4,418 | |
| Medication Adherence | $1,500 | $2,394 | $3,192 | $3,106 | |
| Waived Copays | $0 | $958 | $1,277 | $1,242 | |
| Pharmacist Counseling | $0 | $750 | $325 | $325 | |
| HealthMapRx Fees | $0 | $216 | $179 | $116 | |
| Total | $9,850 | $9,514 | $9,852 | $9,207 | |
| Projected (without HealthMapRx) | $9,850 | $10,851 | $11,954 | $13,171 | |
| Savings Relative to Baseline | $0 | $336 | ($2) | $643 | |
| **Savings Relative to Projected** | **$0** | **$1,336** | **$2,102** | **$3,963** | **$7,402** |
| **Cumulative ROI [1]** | | **149%** | **158%** | **184%** | |

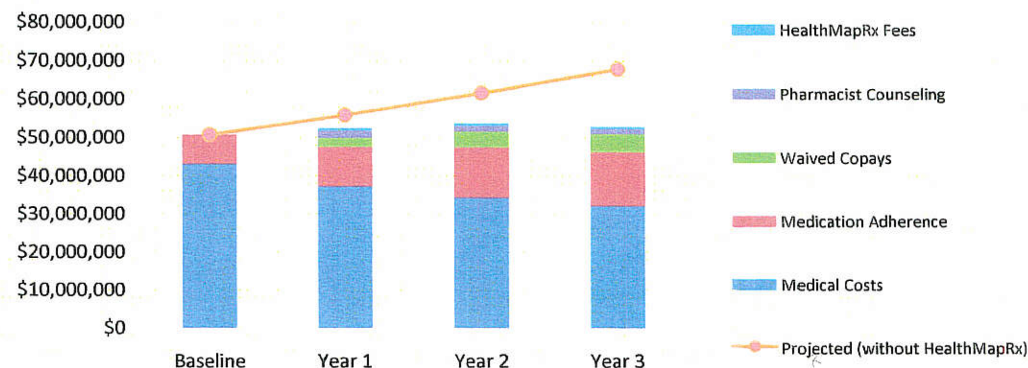
### Population (All Diabetics)

| | Baseline | Year 1 | Year 2 | Year 3 | TOTAL |
|---|---|---|---|---|---|
| Medical Costs | $43,019,200 | $37,175,969 | $34,213,258 | $32,024,543 | |
| Medication Adherence | $7,728,000 | $10,328,843 | $13,276,217 | $14,196,539 | |
| Waived Copays | $0 | $2,466,926 | $4,126,663 | $4,713,200 | |
| Pharmacist Counseling | $0 | $1,932,000 | $1,493,450 | $1,431,325 | |
| HealthMapRx Fees | $0 | $556,416 | $616,616 | $448,266 | |
| Total | $50,747,200 | $52,460,154 | $53,726,205 | $52,813,874 | |
| Projected (without HealthMapRx) | $50,747,200 | $55,902,291 | $61,586,565 | $67,854,787 | |
| Savings Relative to Baseline | $0 | ($1,712,954) | ($2,979,005) | ($2,066,674) | |
| **Savings Relative to Projected** | **$0** | **$3,442,138** | **$7,860,361** | **$15,040,914** | **$26,343,412** |
| **Cumulative ROI [1]** | | **149%** | **165%** | **192%** | |

### RESULTS - Per Participating Patient




### RESULTS - Population (All Diabetics)




[1] Cumulative ROI is defined as "Medical Cost Savings Relative to Projected" to date divided by program costs to date. Program costs are defined as increased medication adherence costs relative to projected medication costs; waived copays; pharmacist counseling fees; and HealthMapRx fees. Details of the ROI calculation are shown in the ROI worksheet.

© 2008 APhA Foundation. All Rights Reserved.
By viewing this page I have agreed to the terms defined at the start of this Savings Calculator [click here for det

## Senate Public Health & Welfare Committee

## Chronic Disease Management Update
## January 20, 2009

**Barbara Langner, PhD.**
**Policy Director**

1

## Objectives

- Review on-going chronic care management initiatives at KHPA
  - CMS health promotion grant for disabled
  - Enhanced Care Management pilot in Wichita
  - State Employee Health Plan: Health Dialog
- Discuss medical home initiative
  - Chronic care management a key goal of medical home model for Kansas

2

## Health Promotion for Kansans with Disabilities

### Improving Preventive Health for disabled Kansans enrolled in Medicaid

- Kansas awarded $900,000 in January, 2008
- Part of $150 million approved by Congress for "Medicaid transformation grants" (MTG)
- Kansas was one of 27 states to receive funding

3

## MTG Project Need

Generally, people with disabilities:

- Are less likely to receive preventive health care services;
- Have high rates of chronic disease (often more than one);
- Have high rates of medication-related problems;
- Fare poorly when it comes to the management of their chronic conditions;
- Face a variety of barriers including access to and coordination of quality health care.

4

## MTG Project Description

A one year intervention
- Case managers and independent living counselors access to an electronic on-line tool (Ingenix Impact Pro).
- The tool also "flags" opportunities for improving quality of care by indicating "gaps" in care.
- Case managers can have discussions with their beneficiaries about the importance and necessity of having screenings conducted and regularly monitoring their conditions.

## MTG Pilot Sites

Four Community Developmental Disability Organizations (CDDOs) and three Independent Living Centers (ILCs) from primarily rural locations across Kansas

- Nemaha County Training Center, Seneca
- Developmental Services of NW Kansas, Hays
- Disability Planning Organization of Kansas, Salina
- Class LTD, Columbus
- Three Rivers, Inc., Wamego
- Prairie Independent Living Resource Center, Hutchison
- Center for Independent Living of SW Kansas, Garden City

Approximately 1,700 beneficiaries are served by about 90 case managers and independent living counselors across these agencies

# MTG Project Partners

The University of Kansas Medical Center Schools of Medicine and Pharmacy (Principal Investigator is Theresa Shireman, PhD)

Ingenix Public Sector Solutions, Inc.

7

# MTG Preliminary Findings

Preliminary findings show significant opportunities to help these beneficiaries with preventive care:

- Care opportunities are being missed for beneficiaries struggling with chronic diseases such as diabetes, depression, coronary artery disease, congestive heart failure and asthma.
- Preventive opportunities are also being missed for cancer screenings, cardiac event prevention, osteoporosis screening and pain management.

8

# Next Steps

$250,050 SGF requested for FY2010

1700 beneficiaries in pilot will continue to be served by case managers and consumers across the State will be added

Services provided by pilot will be expanded to include all aged and disabled beneficiaries statewide

Outreach information targeted to beneficiaries, primary care physicians, pharmacists, and other sources of care.

Risk modeling effort would be continued

Advisory group would be formed to provide guidance and input on development of project.

9

# Enhanced Care Management (ECM) Project

Pilot project designed to provide care management services to HealthConnect beneficiaries living in Sedgwick County

- In 2005, KHPA received input on care management strategies for chronically-ill Medicaid beneficiaries from the Sedgwick County medical community.
- A contract was negotiated between KHPA and the Central Plains Regional Health Care Foundation to begin a pilot project.
- Pilot project implemented March 1, 2006.

10

# ECM Project Goals

To be effective, care provided to people with chronic conditions must be integrated, interdisciplinary, and use an individualized approach.

- Chronic conditions (e.g., diabetes, hypertension, depression) are persistent and require ongoing treatment and management.
- Currently, the care provided is often fragmented, uncoordinated, or incomplete.

11

# Project Description

- Uses a unique approach to connecting providers and beneficiaries through existing community resources.
- Offers enhanced administrative services to HealthConnect Kansas (HCK) members who have probable or predictable high future health care costs.
- Service delivery is community based and culturally appropriate.
- Based on an Enhanced Primary Case Management (E-PCCM) model which is:
  - Member centered
  - Provider driven
  - Based on a successful model in North Carolina

12

# The ECM Consumers

- Medicaid beneficiaries with chronic health conditions and probable future high risk expenditures of medical resources.
- Typically these are beneficiaries who receive Social Security Income (SSI) benefits.
- Excludes beneficiaries who are:
  - Dually eligible for both Medicaid and Medicare
  - Participating in a Home and Community Based Service (HCBS) waiver
  - Residing in a Long Term Care (LTC) facility
  - Participating in one of two capitated managed care organizations
- Eligible beneficiaries are invited to receive services; participation is strictly voluntary

13

# The ECM Care Management Team

- Includes a nurse, a social resource manager, and a physician
- Offers services including:
  - Assessing health and social needs
  - Reviewing utilization trends
  - Reconnecting members with their primary care case management (PCCM) provider
  - Ensuring members fill and take necessary prescriptions
  - Teaching members how to manage their own health conditions
  - Assisting members with accessing community resources (e.g., affordable housing, food, utility assistance, clothing, mental health and substance abuse services, credit counseling and other)

14

# The ECM Team Approach

Staff establish relationships with members in their homes, using creative outreach techniques.

Care managers assist members with focusing on their chronic conditions, social risk factors, and unhealthy lifestyle behaviors.

Intervention involves a holistic approach, focusing on assisting members with accessing resources in the community in order to improve their health.

15

# ECM Project Demographics

An internal analysis of the ECM project conducted by Central Plains Regional Health Care Foundation found:

- Of the 1,707 potential members who were invited to participate, 331 (19.4%) enrolled.
- Beneficiary status at 18 months showed 154 beneficiaries (58.6%) were active and that 143 had disenrolled
- The mean and median number of state identified chronic conditions per beneficiary was 2.8 and 3.0 respectively.
- Of 397 referrals that were made, the majority were made to social services (58.2%), followed by medical services (23.6%) and dental services (18.2%).
- Care plans were initiated on all beneficiaries who enrolled and remained active.

As of February 14, 2008 ECM had 194 actively enrolled beneficiaries

16

# ECM Early Evaluation

Evaluation of ECM participants with at least six months of continuous enrollment prior to 12/31/06 compared ECM consumers to similar reference group in Wyandotte (WY) County:

- Overall costs between baseline and follow-up were flat in ECM group, but increased in WY reference group;
- Costs related to inpatient events reduced more in ECM group than in WY group;
- Number of inpatient events in ECM population declined relative to WY group and differences were statistically significant;

# ECM Early Evaluation (cont.)

- Number of emergency department events in ECM declined relative to WY group, but differences were not statistically significant;
- Number of individuals with repeat visits to emergency department in pre-intervention period compared to post-intervention period in ECM declined substantially and declines were statistically significant.
- Evaluation efforts ongoing to look at health outcomes and cost savings.

## State Employee Health Plan

HealthQuest contains many components and many avenues for participants to interact with the program:

- Online Programs and Tools
  - Dialog Center
  - Personal Health Assessment
- Onsite Health Screenings
- Health Coaching Services
  - General Health Coaching and Symptom Support
  - Targeted Outreach
  - Lifestyle Coaching

19

## State Employee Health Plan

Members can access online tools through the Dialog Center including:

- Personal Health Assessment
- Health Information – *Healthwise® Knowledgebase* and *Health Crossroads*™
- Secure messaging to a Health Coach
- Medication Tracker and Symptom Diary

Online Health Programs through HealthMedia®

- Breathe™ —*Take steps to quit smoking*
- Balance™ — *Manage your weight and physical activity*
- Nourish™ — *Make healthy eating decisions*
- Relax™ — *Manage stress*
- Care™ for Your Back — *Prevent and treat low back pain*

20

## State Employee Health Plan

A member can log on to take the Personal Health Assessment to assess health risks

They will receive:

- A Health Risk Summary
- Links to Health Information in the Dialog Center
- Information on contacting a Health Coach and the HealthQuest program
- $50 gift card

21

## State Employee Health Plan

Health Screenings were offered at 51 sites in 37 cities

Starting January 22, 2008

These screenings offer:

- Blood pressure
- Height & weight
- BMI calculation
- Total Cholesterol (finger stick)
  - HDL
  - LDL
- Ratio TC/HDL
- Triglycerides
- Glucose

A health professional will review the results with each individual and refer to a health coach, as needed

22

# State Employee Health Plan

- Participants may be invited to participate in lifestyle coaching program
- Three Lifestyle Coaching programs will be offered:
  - iCanQuit – Smoking Cessation
  - iCanChange – Weight Management
  - iCanRelax – Stress Management
- Each program offers telephonic coaching, workbooks and fun items to motivate and support participants
- A Healthy Lifestyle Coach will:
  - Begin by reviewing participant's history, habits and goals.
  - Send participants useful information to reinforce learnings from the coaching sessions.
  - Be available by calling the toll-free support line

23

# State Employee Health Plan

- Two main ways for members to interact with a health coach:
  - Member calls in for health information or support of a condition
  - Identification by predictive model as having a chronic illness or preference sensitive condition
- Members may receive direct outreach via telephone, AutoDialog or mail
- There are various onsite promotional materials that can be used to make members aware of the HealthQuest coaching line

24

# State Employee Health Plan

- Whole person, whole family
- Primary Coach model
  - Over 70% of engagements are with an individual's personal coach
  - Other professionals available include Registered Dietitians, Respiratory Therapists, Pharmacists, Clinical Resource Specialists
- Focused on building self-reliance, not dependence
  - Motivational Interviewing techniques
  - Shared Decision-Making® certification
- Purposeful, but not scripted, interactions
- Powerful, yet easy to use, support tools
- Health Coach and individual empowerment

25

# Medical Home and Senate Bill 81

- House Substitute for Senate Bill 81 (SB81) was signed into law in June, 2008.
- Among these reform policies is the definition of a medical home.
- The bill also directs KHPA to:
  - Incorporate the use of the medical home delivery system within the Kansas:
    - Medicaid
    - HealthWave
    - MediKan, and
    - State Employees Health Benefit Plan; and
  - Work with the Department of Health and Environment (KDHE) and stakeholders to "develop systems and standards for the implementation and administration of a medical home in Kansas."

26

## Medical Home Work Plan

Long term goal: Help transform the health care system in Kansas.

Short term goal: Gain support from stakeholders and policymakers for payment reform to develop the medical home health care delivery model.

Medical home model informed by chronic disease management model AND pediatric case management model.

The development of the medical home model will be informed by a strong stakeholder process to achieve appropriate buy in and feedback from stakeholders.

Phase I: July 2008 – July 2009; Phase II: July 2009 – July 2010.

27

## Medical Home Work Plan (cont.)

Overall work plan strategies:

- Determine process for defining medical home in statute (2008)
- Develop stakeholder process to analyze medical home definition options, including NCQA standards (2008/2009)
- Obtain feedback from Advisory Councils (2009)
- The KHPA Board will consider and approve the medical home definition and payment incentives for whole person care coordination, health and wellness (2009)
- Implement medical home incentive payments/contractual rate adjustments in SEHP and Medicaid/HealthWave (2010/2011)
- Evaluate medical home payment incentives/contractual rate adjustments in SEHP and Medicaid/HealthWave (2012)

28

# Activities to Date

Key stakeholders met on September 29, 2008 to:

- Review national medical home criteria;
- Select the criteria most relevant to Kansas; and
- How payment should be structured.

As a result of this discussion, three sub-groups were formed to explore:

- Ideas for marketing the medical home in Kansas;
- How the Joint Principles of the Patient-Centered Medical Home can be applied in the Kansas health care environment; and
- Identification of design considerations for potential pilot projects in Kansas.

Stakeholders met on November 19th to discuss sub-group's findings.

29

# Continuing Phase I Activities

Outreach to foundations and others for consideration of support to the development of a medical home model;

Development of a communication strategy for discussing a medical home model in Kansas; and

Finalizing the "Medicaid Transformation Plan" for Kansas, including identifying current policies that promote a medical home for various Medicaid populations.

30

## Medical Home and Chronic Disease Management

Medical home model likely to be piloted first, comparing needs and capacity in urban vs. rural communities.

Medical home model will use lessons learned from CMS grant and ECM pilot.

Medical home model should incorporate best practice chronic disease management.

Medical home pilots still under development.