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Medicaid Policy Changes in Kentucky under the Deficit Reduction Act of 2005: Implementation Issues and Remaining Challenges

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LIST OF ABBREVIATIONS

AWP	Average Wholesale Price
CHFS	Cabinet for Health and Family Services
CMS	Centers for Medicare and Medicaid Services
DM	Disease Management
DRA	Deficit Reduction Act
ESI	Employer-Sponsored Insurance
FPL	Federal Poverty Level
HIPP	Health Insurance Premium Program
KCHIP	Kentucky Children’s Health Insurance Program
MMIS	Medicaid Management Information System
SPA	State Plan Amendment

EXECUTIVE SUMMARY

In 2006, Kentucky became one of the first states in the nation to implement changes to its Medicaid program under authority granted by the 2005 Deficit Reduction Act (DRA) (PL 109-171). The policy changes, known as KyHealth Choices, was approved through a series of state plan amendments (SPAs) allowing Kentucky greater flexibility in benefit design, cost-sharing, and innovative initiatives designed to coordinate care, promote healthy behavior and manage chronic diseases. Because it was one of the first states to take advantage of the DRA provisions to redesign Medicaid, Kentucky's experience may be useful to other states looking to introduce similar policies in their Medicaid programs, although it is not clear the extent to which the current administration at the Centers for Medicare and Medicaid Services (CMS) will encourage the use of the DRA as a vehicle for state health care policy change.

In Kentucky, the proposed changes included the creation of targeted benefit packages for different categories of enrollees, increases in member cost-sharing, soft service limits (which can be overridden on request by a physician in the case of medical necessity), "Get Healthy" benefits to reward healthy behaviors, the promotion of employer-sponsored insurance (ESI) through a premium assistance program, a parent buy-in to the Medicaid program, redesign of the Kentucky Children's Health Insurance Program (KCHIP), and disease management (DM) programs.

In May 2006, CMS approved Kentucky's state plan amendment, creating KyHealth Choices. The approved major changes affecting low-income children and families include:

- Targeted benefit packages designed for 1) non-disabled adults, pregnant women, and some children (*Global Choices*), 2) most children (*Family Choices*), 3) enrollees with developmental disabilities or mental retardation requiring services at an intermediate care facility (*Optimum Choices*), and 4) the elderly and enrollees with disabilities (*Comprehensive Choices*);
- New cost-sharing requirements in the form of copayments for physician, emergency, and inpatient services and prescription drugs, and service limits on specialty visits and prescription drugs;
- Disease management pilot programs targeting chronic conditions that could be managed successfully through a partnership between physician and patient;
- "Get Healthy" benefits for enrollees who participate in a disease management program for one year, such as vouchers for dental care, vision hardware, smoking cessation products, or nutrition counseling; and
- Promotion by eligibility and intake workers of the Health Insurance Premium Program (HIPP), which pays for children and families to enroll in employer-sponsored health insurance if it is cost-effective.

Most of the policy changes were implemented beginning in June 2006. In addition, the state made a number of other changes that did not require submission of a SPA. These included enrollment simplification measures, a 2-phase redesign of KCHIP, increases in reimbursement rates for dental, preventive, and evaluation and management services provided to children, and an upgrade of the Medicaid Management Information System (MMIS). The state also contracted with private companies to manage its pharmacy and medical claims and prior authorization requests.

It is not possible to draw definitive conclusions about the effects of Kentucky's Medicaid policy changes, but a number of findings have emerged four years into implementation. While Kentucky succeeded in meeting some of the original goals of its policy change effort, progress towards other goals has been limited. Successes include:

- Demonstration that change and innovation are possible in Medicaid;
- An effort to control costs and promote utilization of primary and preventive care through implementation of the targeted benefit packages, new copayments and service limits, increased reimbursement levels, increased dental benefits for children, and prescription drug reimbursement changes;
- Apparent increased enrollment in KCHIP following enrollment simplifications and redesign;

- An upgraded MMIS and new web-based KyHealth-Net that allows providers to look at their patients' claims history and could serve as a building block for electronic health records or future data-driven disease management initiatives; and
- Increased collaboration between the Cabinet for Health and Family Services and advocacy organizations in the state.
- Lack of data systems for accurate surveillance on health status, access, and cost indicators;
- Lack of available funds for the new initiatives (e.g. Get Healthy Benefits); and
- Reported lack of policy continuity in CMS across departments and over time, making it difficult for policy makers in the state to design and get approval for policy changes.

The factors that facilitated these successes include:

- Clear vision and leadership from the governor's office and the Cabinet for Health and Family Services early in the process; and
- The presence of the Passport Health Plan in the Louisville region, which provides examples of promising initiatives for the Kentucky context.

Despite these successes, a number of barriers have tempered the impact of some of the policy changes. These include:

- Pressures to fulfill daily responsibilities amid high turnover and staffing shortages that may have inhibited progress;
- Implementation problems with contractors for the claims administration system and some disease management programs;
- Incomplete implementation of the disease management programs and political and geographical issues over where to locate the pilot sites;
- Lack of examples of successful patient incentive programs;
- Confusion among enrollees and providers over new cost-sharing requirements and service limits;

In general, key informants in the state did not perceive that the implemented changes addressed the root sources of access, cost and quality problems in Medicaid and therefore did not expect the policy changes to lead to noticeable changes in these areas. Several informants also expressed doubts regarding the ability of KyHealth Choices' policy changes to have meaningful effects on program costs or health behaviors. It is likely that additional policy changes related to Medicaid coverage of benefits for substance abuse treatment, smoking cessation services, and family planning services; the fragmentation in financing for mental health services; provider capacity issues; and inefficiencies with regard to the distribution of health care resources will be needed for KyHealth Choices to achieve its goals. Future Medicaid initiatives in these areas will depend on how the state weathers the current economic storm and on the policy changes that accompany federal efforts to reform the health care system.

Medicaid Policy Changes in Kentucky under the Deficit Reduction Act of 2005: Implementation Issues and Remaining Challenges

INTRODUCTION

In 2006, Kentucky became one of the first states in the nation to implement changes to its Medicaid program under authority granted by the 2005 Deficit Reduction Act (DRA) (PL 109-171). The Deficit Reduction Act of 2005, signed into law in February 2006, gave states new flexibility in the design of their Medicaid programs, including allowing states to tailor benefit packages to different categories of enrollees, expanded options for premium assistance for private health insurance, and increased flexibility in designing new systems for long term care coordination (Centers for Medicare and Medicaid Services “The Deficit Reduction Act.”).

In particular, the DRA provided states with a new vehicle for making changes to their programs, allowing the use of a state plan amendment (SPA) for policy changes that previously would have required a waiver. The ability to bypass a waiver using a SPA allows for policy changes that are not budget neutral and that do not need to be renewed (Rudowitz and Schneider 2006). The DRA also relaxed two requirements that previously governed Medicaid programs, statewideness and comparability (Health Management Associates 2007). Statewideness refers to the availability of all Medicaid services and programs in all areas of a state; comparability refers to the availability of all Medicaid services and programs to all eligibility groups. Relaxing these two standards allows states to implement pilot programs in only one part of the state and to tailor benefit packages to the needs of different eligibility groups (Health Management Associates 2007).

Two key provisions of the DRA relate to changes in benefits and cost-sharing for enrollees. The DRA allows states to create benchmark benefit packages that offer different benefits to different categories of enrollees. Similar to states’ options when designing benefit packages in the Children’s Health Insurance Program (CHIP), the benchmark benefits can be the Blue Cross/Blue Shield option under the Federal Employee Health Benefits Plan, the plan offered to state employees, the plan offered by the largest health management organization in the state, secretary-approved coverage, or “benchmark equivalent” coverage, which must have the same actuarial value as one of the options listed above. Benchmark benefit packages must be voluntary for cer-

tain groups of enrollees, including pregnant women with income less than 133 percent of the federal poverty level (FPL), the blind or disabled, those dually eligible for Medicaid and Medicare, terminally ill hospice care recipients, foster/adoption assistance children, long term care recipients, and women who are eligible for breast and cervical cancer programs. In addition, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefits must continue to be offered to all children under age 19 enrolled in Medicaid (Health Management Associates 2007).

The new cost-sharing rules in the DRA apply only to enrollees with income above the FPL. Those with income between 100 and 150 percent of the FPL may be charged up to 10 percent of the cost of the service they receive, and those with income above 150 percent of the FPL may be charged up to 20 percent of the cost of the service. However, cost-sharing remains prohibited for emergency services, family planning services and supplies, and preventive care services for children under age 18, and all services for certain groups (e.g., children under age 18 in mandatory eligibility categories, pregnant women, etc.). For those beneficiaries who face cost-sharing requirements, total out-of-pocket spending may not exceed 5 percent of family income. An important change in the DRA is that states are allowed to make cost-sharing enforceable, that is, the state may terminate coverage or the provider may deny services for failure to pay (Health Management Associates 2007).

The policy changes in Kentucky, known as KyHealth Choices, were approved through a series of state plan amendments (SPAs) allowing greater flexibility in benefit design, cost-sharing, and innovative initiatives designed to coordinate care, promote healthy behavior and manage chronic diseases. Because it was one of the first states to take advantage of the DRA provisions to redesign Medicaid, an analysis of Kentucky’s experience will be useful to other states looking at options to introduce similar policies in their Medicaid programs, although it is not clear the extent to which CMS under the current administration will encourage the use of the DRA as a vehicle for state health care reform.

This report outlines Kentucky’s process of adopting and implementing its Medicaid policy changes. The informa-

tion contained in the report comes from discussions in late 2008 and the first half of 2009 with state officials, advocates, and providers; documents available from the state's website; and external reports and analyses of the state's experience with the policy changes. Unless otherwise cited, findings in this paper are based on the key informant interviews. The focus of this report and of the project more broadly is on the policy changes that affected children and non-elderly adults.¹ Policy questions related to long-term care and individuals dually eligible for Medicaid and Medicare are outside the scope of this study. Subsequent reports will examine how service use patterns have been changing over time and, where possible, will assess the impacts of particular Medicaid policy changes that were made.

BACKGROUND

Relative to the rest of the nation, Kentucky has one of the highest rates of obesity, diabetes, and overall mortality, and also has high mortality rates due to cancer and cardiovascular disease (KyHealth Choices 2006). Kentucky's health profile is likely driven in large part by its high poverty rate.

Kentucky's Medicaid program plays an important role in providing health care to residents of the state. In 2005, Medicaid accounted for 22 percent of the state government's annual expenditures and provided coverage for over 15 percent of the state's population. Medicaid enrollment grew by 30 percent between the late 1990s and 2005, and the Medicaid program reportedly experienced deficits of over \$400 million per year earlier this decade (KyHealth Choices 2006). Out of this environment emerged a desire to reform Kentucky's Medicaid program to ensure that it would be sustainable for future generations, and to encourage the greater use of preventive care and the adoption of healthier lifestyles (KyHealth Choices 2006).

Medicaid coverage in Kentucky, as in other states, reflects a patchwork of eligibility categories. Kentucky covers infants under 1 year of age and pregnant women up to 185 percent of the federal poverty level (FPL).² Children aged 1 to 6 years are covered up to 150 percent of the FPL under Title XIX of the state's Medicaid program, while those aged 6 to 18 are covered up to 100 percent of the FPL under Title XIX and between 101-150 percent of the FPL under a Title XXI-funded Medicaid expansion. Children aged 1 to 18 with incomes between 151-200 percent of the FPL are covered under a Title XXI-funded separate program known as the Kentucky Children's Health Insurance Program, or KCHIP.³ Medicaid coverage is also available for working parents up to

64 percent of the FPL and nonworking parents up to 37 percent of the FPL (Cohen Ross 2009).

In FY 2005, Kentucky's Medicaid program spent just over \$4 billion in state and federal funds to cover 845,000 Kentuckians. Kentucky has a favorable federal matching rate, receiving a 69.78 percent match rate on its Medicaid spending and a 78.85 percent match rate on its KCHIP spending in FY 2008 (Assistant Secretary for Planning and Evaluation 2010).⁴

About half (49 percent), or about 350,000, of Medicaid enrollees are non-disabled children (Kentucky MS-264 Data 2007). Another 68,800 children were covered under the separate KCHIP program in fiscal year 2007 (Peterson 2008), costing an additional \$100 million (Centers for Medicare and Medicaid Services 2008). Non-disabled adults, including parents and pregnant women, constitute 16 percent of Medicaid enrollees, and non-disabled elderly adults who are dually eligible for Medicaid and Medicare account for 6 percent of enrollees (Kentucky MS-264 Data 2007). Another 27 percent of enrollees qualify as disabled, 15 percent of whom are children and two-thirds of whom are non-elderly adults.⁵

Consistent with the patterns found in other states, Kentucky's Medicaid spending is concentrated on the elderly and the disabled (Holahan et al. 2009a; Holahan et al. 2009b). The disabled population is the group with the highest expenditure share, constituting 44 percent of total Medicaid expenditures, or \$1.8 billion. The next largest expenditure share is spent on the elderly, making up 24 percent of expenditures (\$960 million), while other adults, including parents and pregnant women make up just 11 percent, or \$420 million. Despite the fact that half of the Medicaid caseload in Kentucky is comprised of children, they constitute just 21 percent of Medicaid expenditures (\$850 million) (Urban Institute/Kaiser Commission on Medicaid and the Uninsured 2009).⁶

Kentucky's Medicaid program operates on a fee-for-service basis with a primary care case management component except for 16 counties in the Louisville region (Jefferson, Oldham, Trimble, Carroll, Henry, Shelby, Spencer, Bullitt, Nelson, Washington, Marion, Larue, Hardin, Grayson, Meade, Breckinridge). The Medicaid program operates the Medicaid Health Care Partnership Program, known as the Passport Health Plan, in 16 counties in the Louisville region and accounts for about 17 percent of the caseload in Kentucky's Medicaid program.⁷ The program operates with an 1115 Waiver from CMS under a capitated managed care model that

began in 1997. While the plan as a whole is capitated, individual providers are not paid a capitated rate, and behavioral and long term care services are carved out, reimbursable on a fee-for-service basis (“Kentucky Medicaid Health Care Partnership Program” 2009).

Kentucky’s Medicaid program includes a primary care case management program, called KenPAC, outside the Passport region. Under KenPAC, primary care providers receive a monthly fee of \$4 for each enrollee who is assigned to them (KenPAC Primary Care Case Management Agreement 2006). Enrollees need to obtain referrals for some specialty services from their primary care providers.

KENTUCKY’S PROPOSED MEDICAID POLICY CHANGES

In November 2005, Kentucky submitted an 1115 Demonstration Waiver to the Centers for Medicare and Medicaid Services (CMS) to make significant changes to its Medicaid program. Beginning in 2004, under the gubernatorial administration of Republican Ernie Fletcher, M.D., Kentucky’s Cabinet for Health and Family Services (CHFS) had been working on a proposed redesign of its Medicaid program. The redesign sought to encourage more effective use of state Medicaid resources and greater involvement of Medicaid beneficiaries in their health care through implementation of strategies typically found in commercial insurance plans. The stated goals of the proposed transformation of Medicaid (KyHealth Choices 2005) were to:

- Improve the health status of those Kentuckians enrolled in the program;
- Ensure a continuum of care;
- Guarantee individual choice; and
- Ensure the solvency of Kentucky Medicaid for future generations of Kentuckians.

CHFS sought input from numerous stakeholder groups, including beneficiaries and their families, advocates, and providers in the state as it developed its redesign effort. The plan for the transformation initiative, called KyHealth Choices, was drafted in 2005 by a group that included officials from CHFS and members from both the Advocates for Reforming Medicaid and the Medicaid Consortium, a group of advocates for affordable, accessible health care representing 70 different organizations (Kentucky Medicaid Consortium 2004). Members of

these groups were also engaged in the implementation of the Medicaid policy changes that were ultimately approved.

The passage of the 2005 DRA gave Kentucky the authority to make many of the changes to its Medicaid program with a SPA instead of going through the process of obtaining an 1115 Waiver from CMS. Under the DRA, states were given new options for introducing policies in Medicaid, including creating tailored benefit packages for different populations, expanding options for premium assistance for private health insurance, and relaxing existing standards in designing new systems for long term care coordination (Centers for Medicare and Medicaid Services. “The Deficit Reduction Act”). Kentucky subsequently withdrew its 1115 Waiver application and instead submitted a SPA to CMS in April 2006. The four original goals were reframed as two overarching goals articulated by the governor’s office and other key stakeholders involved in the design of the policy changes (KyHealth Choices 2006):

1. Stretch resources to most appropriately meet the needs of members; and
2. Encourage Medicaid members to be personally responsible for their own health care.

In addition, four principles guided the design of the policy changes: quality and prevention, consumer empowerment and choice, personal responsibility, and community solutions (KyHealth Choices 2006).

Kentucky’s original proposal included the creation of targeted benefit packages for different categories of enrollees, increases in member cost-sharing, “soft” service limits (which can be overridden on request by a physician in the case of medical necessity), “Get Healthy” benefits to reward healthy behaviors, the promotion of employer-sponsored insurance (ESI) through a premium assistance program, a parent buy-in to the Medicaid program, a redesign of the Kentucky Children’s Health Insurance Program (KCHIP), and disease management (DM) pilot programs (Health Management Associates 2006). Some details in the proposal were changed during the CMS approval process. A description of the changes approved by CMS appears below, with reference to specific changes where they occurred.

CHANGES APPROVED BY CMS

On May 3, 2006, the CMS approved Kentucky's SPA creating KyHealth Choices. The policy changes consisted of the following major components:

1. Targeted benefit packages
2. Cost-sharing and service limits
3. Disease management programs
4. "Get Healthy" benefits
5. Health Insurance Premium Program (HIPP)⁸

Targeted Benefit Packages

Four new benefit packages were proposed that offered coverage for varying ranges of services, depending on the program's characterization of covered populations' needs.

The *Global Choices* plan is the standard Medicaid plan covering the majority of adult Medicaid beneficiaries, excluding dually eligible enrollees or individuals who require long-term care. The Global Choices plan covers pregnant women, parents, foster children, medically fragile children, groups covered under Supplemental Security Income, and breast and cervical cancer patients (Kaiser Commission on Medicaid and the Uninsured 2006). The plan covers basic medical services, excluding long-term care services.

The *Family Choices* plan is designed specifically for children and covers all KCHIP child enrollees and some children in traditional Medicaid. This plan added a second annual dental visit to its list of covered services, has a more generous vision benefit, and does not have the prescription drug limit found in the Global Choices Plan (see section on service limits below). Because this plan is designed for children, some benefits covered in the Global Choices Plan are not covered under Family Choices, including maternity care, podiatry services, and care for end-stage renal disease and transplants.

Two plans were also designed to meet the needs of members requiring long-term care. *Optimum Choices* covers members with mental retardation and developmental disabilities and those currently in the Supports for Community Living 1115 Waiver. In addition to the services provided under *Global Choices*, members in this plan also receive coverage for intermediate care facilities. The plan has three levels of care for long-term care

services: high intensity, which includes coverage for institutionalization, targeted, and basic.

Comprehensive Choices covers the elderly and members with disabilities. The plan covers all benefits in *Global Choices*, plus nursing facility services and services previously covered under three of Kentucky's 1115 Waivers (Acquired Brain Injury, Home and Community Based Waiver, and Model II). The plan has two levels of care for long-term care services: high intensity, which includes coverage for institutionalization, and basic.

Cost-Sharing and Service Limits

The state also proposed new cost-sharing requirements and soft service limits for many members of KyHealth Choices, which were not previously allowed under Medicaid. Enrollees in all four benefit packages were to be subject to maximum out-of-pocket expenditures of \$225 for medical services and \$225 for pharmacy services (\$450 total) per year. In addition, copayments were not to exceed 5 percent of family income per quarter. Proposed copayments were typically \$3-6 for physician services, including specialty services, \$2 for dental services (Global Choices only), and \$1-2 for prescription drugs. Non-preferred drugs were also to be subject to a 5 percent coinsurance in all plans except Family Choices, and members of Global Choices were to pay a \$50 copayment for inpatient hospital services. Kentucky's original proposal included higher copayment amounts for prescription drugs (\$5-\$15) and for non-emergency use of the emergency room. Given the likelihood that higher copayments would exceed federal limits on beneficiary out-of-pocket costs and expressions of concern from the advocacy community about these provisions, the copayment amounts were reduced to \$1-3 for prescriptions and 5 percent coinsurance for non-emergency use of the emergency room, up to a maximum of \$6 (Seckel 2006). A number of beneficiary groups were exempt from cost-sharing, including non-KCHIP children, foster children, pregnant women, hospice care patients, and Personal Care or Family Care Home recipients. No copayments were proposed for preventive care visits.

The new proposed service limits were designed to be "soft," that is, they could be overridden on request by a physician in the case of medical necessity. The proposed limits included annual maximums on the number of specialty visits (chiropractic services, physical therapy, podiatry, etc.) and a monthly limit of four prescription drugs (with a maximum of three brand-name drugs). The prescription drug limits did not apply to children under 19 and to members diagnosed with certain chron-

ic conditions.⁹ Providers could override service limits by going through a prior authorization process.

Disease management programs

The new disease management programs were designed by the Division of Medical Management in the state Medicaid office under contract with FirstHealth, a subsidiary of Coventry Health Care. The state planned to roll out pilot programs for nine disease management programs and three wellness initiatives in select counties. For the disease management programs, claims files and pharmacy records were to be used to identify members with specific chronic conditions that could be managed successfully through a partnership between physician and patient. The programs would include various types of reminders, frequent check-ups and promotion of healthy behaviors such as engaging in physical activity and making dietary modifications.

“Get Healthy” Benefits

CMS approved the provision of Get Healthy Benefits to members who successfully participated in a disease management program for one year and complied with recommended age and periodicity screening guidelines. Members would be allowed to choose from 1) up to \$50 for dental services; 2) up to \$50 for vision hardware services; 3) five visits to a nutritionist or registered dietitian for meal planning and counseling; or 4) two months of smoking cessation assistance through a local health department, including two months of nicotine replacement therapy. Participants would have up to six months to access the benefit.

Health Insurance Premium Program (HIPP)

Kentucky’s Health Insurance Premium Program provides direct premium assistance for Medicaid members to enroll in employer-sponsored insurance if doing so would cost the state less than Medicaid coverage. Because enrollment was very low before KyHealth Choices implementation, the state planned to encourage eligibility and intake workers to promote the program. Members would be allowed to reapply for coverage under Medicaid if they chose to drop their ESI coverage after at least 90 days of enrollment. Wrap-around benefits would continue to be provided to participants under the age of 19 and for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services under the terms of the CMS-approved state plan.¹⁰

Other Changes

While not part of KyHealth Choices, another important change to Kentucky’s public insurance programs was the proposed KCHIP redesign, which was to involve two phases. The first phase included approval in 2001 for a conversion of Kentucky’s Medicaid look-alike program into a separate, stand-alone program for infants and children up to 200 percent of the FPL as well as the addition in 2003 of \$20 monthly premium charges for children in families with income above 150 percent of the FPL.¹¹ In phase two, which was approved in 2006, the state would issue a request for proposals to contract with a private insurer to manage and operate the KCHIP program on an at-risk basis, provided that it would be more cost-effective than administering the program publicly. The state also proposed ending coverage for inpatient and outpatient substance abuse services and added copayments for prescription medications, office visits, allergy testing, and non-emergency use of the emergency room for their separate KCHIP program (Kentucky Title XXI State Plan 2007).

Kentucky introduced a number of systems changes designed to support its redesign effort. In particular, the state upgraded its Medical Management Information System (MMIS) and contracted with First Health to serve as both a Pharmacy Benefit Administrator and the Kentucky Medicaid Administrative Agent, responsible for developing and administering policies related to utilization management, clinical review, and practice guidelines for disease management initiatives (“Kentucky Awards Medicaid...” 2005). In addition, the prior authorization process for overriding service limits was contracted to SHPS, Inc., an independent health management and benefits administrator headquartered in Louisville.

As part of the new MMIS, providers have access to an upgraded website with provider resources (KyHealth-Net) including prior authorization support functions, online claims submission and adjudication, claims status inquiry, member profiles (including eligibility, copayment history, KenPAC provider, poverty indicator, and other information), member service limitation and pharmacy histories, and a list of the providers’ current KenPAC patients (KyHealth-Net System 2008).

IMPLEMENTATION OF POLICY CHANGES

Benefit and Cost-Sharing Changes

Kentucky began implementing its policy changes related to the DRA in June of 2006 (Table 1). Between June and December 2006, the state introduced the new benefit

packages and implemented new copayments, soft service limits, and prior authorization requirements. The number of allowable dental visits for children was increased to two per year, the cost of which was offset by limiting adult dental benefits to an annual benefit maximum and allowing no more than one dental visit per year, regardless of medical necessity (Preventive Health Fee Schedule 2008).

Kentucky used several methods to communicate the changes in the Medicaid program to beneficiaries and providers during the first months of implementation. Providers received letters in May 2006 to inform them of the new service and prescription drug limits, prior authorization requirements, the process of collecting copayments from patients with income below the FPL—who could not be denied prescriptions for failure to pay—and other changes. A series of provider forums across the state also addressed the newly implemented policies, and a seminar series targeted prescription drug issues. Beneficiaries were automatically placed into the new benefit packages based on their prior eligibility category and claims history, and they received letters informing them of the benefit plan in which they were placed and outlining which services were subject to limits and copayments.

Despite these efforts, some members and providers did not understand all the changes. Many members reported having difficulty understanding the technical language used in the letters or the differences in covered benefits across the plans, leaving them to rely on word of mouth or their primary care physicians and pharmacists to help them understand the changes (Harris 2008). In addition, the letters did not inform members of their legal right to opt out of the new benefit plans and retain their traditional Medicaid coverage.

The service limits were an area of particular confusion for parents and providers. Some parents reported being told by doctors' offices or pharmacies that Medicaid would not cover more than four prescriptions for their child, even though children under age 19 are exempted from the four prescription limit. In addition, the prior authorization process for overriding the soft limit was confusing to parents, who did not know how it worked or what to do if a request was denied (Harris 2008). Information on the process for overriding the service limits was lacking in the letters sent to Medicaid members, and there was no mention of the fact that EPSDT services were not subject to service limits (Regan 2006).

Two important implementation issues the state addressed are 1) ensuring that Medicaid recipients with income less than the FPL were not denied services due to inability to pay the copayment, as mandated by federal law, and 2) ensuring that the copayments did not deter enrollees from seeking care when medically necessary (Seckel 2006). The state Medicaid office added a poverty level indicator to its MMIS which appeared at the point of sale reading "Dispense Regardless of Co-Pay Collection," to inform the pharmacist that the patient was below the qualifying income limit. Posters were distributed to pharmacies to inform members of the four prescription limit (Pharmacy Program Information 2008). However, no comparable poverty indicator flag appears for physicians who charge copayments at the point of service. Physicians and their staff would have to check their patients' poverty status online using Ky-Health-Net in order to access this information. In addition, the state does not appear to be monitoring whether beneficiaries are meeting the out-of-pocket limits, raising a concern that some (most likely those in poorer health who are using more services and more prescriptions) may be paying more for their care than was intended.

The disease management programs were implemented by the Division of Medical Management in the state Medicaid office under contract with FirstHealth. The state implemented its intended pilot programs for nine disease management programs and three wellness initiatives in select counties. The counties receiving the most attention from disease management initiatives were in the Appalachian region, an area with longstanding elevated rates of chronic disease (Table 2).

In most cases, the disease management programs were low-intensity, involving the distribution of brochures, newsletters or post cards to remind patients about the kinds of activities recommended to address their health conditions. For example, the breast and cervical cancer screening initiative distributed reminders to Medicaid beneficiaries when they visited the local eligibility determination offices in the 9-county target area, mailed birthday cards with instructions for obtaining mammograms and Pap smears to all age- and gender-appropriate Medicaid beneficiaries in the target area, supplied educational bookmarks to local bookstores and libraries, and visited local healthcare providers to review national guidelines and solicit support. The program also provided a participating woman with a \$10 incentive payment when she submitted evidence that she had completed either mammography or the Pap test, for a possible total of \$20 per participant. The funding

for the incentive payments came under a grant from the Foundation for a Healthy Kentucky. Of the 7,000 birthday cards that were distributed in the target area, 270 were returned; 86 percent (231) of the returned cards documented eligible services and resulted in incentive payments.

Programs addressing heart failure and coronary artery disease were implemented in 2006 in all counties except those served by the Passport Medicaid plan. The heart failure program encouraged patient participation through regional screenings, solicitation through provider offices, and letters to beneficiaries in the targeted age range of 40-65. Those who enrolled were sent 12 educational mailings including specific materials for enrollees with diabetes (a common co-morbidity), completed a baseline health risk assessment, received modest incentives for ongoing participation, and were asked to complete a participant satisfaction survey upon program completion. Providers received quarterly mailings with clinical updates, epidemiological trends, and practice tips. The coronary artery disease program, one of the three wellness initiatives, consisted of a single reminder postcard highlighting lifestyle changes that reduce the risk of coronary artery disease.

The diabetes program was contracted to FirstHealth and promoted self-management through the provision of newsletters, wallet cards with reminders, a diabetes management schedule of such assessments as eye and foot checks, American Diabetes Association website information, and other educational material. While the program's interventions were designed to be a partnership with the public health agencies in the state, limited communication with providers and lack of coordination with existing state-funded, health department-based diabetes centers of excellence across the state limited the visibility of this partnership. Following termination of the state's contract with First Health, the diabetes disease management program was moved to the Department for Public Health, to be administered in collaboration with the state-funded Diabetes Centers of Excellence.

The other disease management initiatives addressed pediatric and adult obesity, pediatric asthma, and pediatric diabetes, and were limited to the counties with the highest number of enrollees on record with the condition in question. The pediatric asthma initiative consisted of an introductory letter to providers and members that included a fact sheet and action plan for managing asthma. A Minority Health initiative (one of the three wellness initiatives) targeted counties with the

highest number of enrollees in the target demographic group (Kentucky Cabinet for Health and Family Services 2009). With the exception of the diabetes program (now run by the Diabetes Centers of Excellence), none of the disease management programs continued past the pilot phase.

The Get Healthy benefits were never implemented due to concerns over their additional costs and concerns from CMS about what benefits would be provided. Specifically, under the DRA, approved benefits were limited to elements that would be part of the range of allowable Medicaid benefits or be of only nominal value. While some of the proposed benefits (smoking cessation therapy, nutrition counseling) would have met the first criteria, others (vouchers for vision hardware) would not have qualified.

Enrollment changes

Implementation of the Health Insurance Premium Program (HIPP) was still continuing as of March 2009. Work was in progress to amend state administrative regulations to conform to the state plan. Efforts also continued to make HIPP a more useful component of the state's health benefit offerings.

A second major enrollment change was unrelated to Ky-Health Choices and took place under the administration of Gov. Steve Beshear. In November 2008, Kentucky simplified enrollment procedures for its KCHIP program by eliminating the face-to-face interview which had been instated in 2001 (Kentucky Title XXI State Plan 2007). This change did not require DRA authority. Applicants can now download the application from the internet and mail it in (Vos 2008). According to state officials, an additional 20,000 children were added to Medicaid and KCHIP between November 2008 and June 2009. This increase is higher than the levels typically experienced over an eight month period. Phase II of KCHIP redesign, which planned to privatize KCHIP, has not been implemented due to difficulty in finding a private insurer willing to administer the program on an at-risk basis, given the small size of the target population.

Financing and reimbursement changes

In 2005, Kentucky had changed its reimbursement policies for prescription drugs to encourage the use of generic medications (Turner 2005). The reimbursement rate for generic drugs was decreased from 12 percent below average wholesale price (AWP) to 14 below AWP while the rate for brand name drugs was decreased to 15 percent below AWP. In addition, the dispensing fee

for generic drugs was raised from \$4.51 to \$5 and for brand name drugs was lowered from \$4.51 to \$4.50. This change was communicated to providers and pharmacists in a letter from the Medicaid Commissioner (Turner 2005).

Reimbursement amounts for prescription drugs were lowered by the amount of the new copayments. Reimbursement amounts were also lowered by the amount of the applicable copayment for inpatient and outpatient services, allergy testing, physical therapy, occupational therapy, speech, laboratory/diagnostic/radiology services, podiatry, and ophthalmology, while no deduction was taken from physician services, non-emergency use of the emergency room, and dental services (Seckel 2006). The lower reimbursements could motivate providers to deny services to patients who are unable to pay the copayment, as allowed under the DRA; however, there is no evidence to suggest whether or not this is occurring in Kentucky.

The state also increased reimbursement for dental services and evaluation and management services, with the goal of increasing access to care among beneficiaries under age 21. These changes did not require DRA authority. For these beneficiaries, there was a 30 percent increase for most dental services (Jennings 2006), a 12.5 percent increase for 14 preventive care codes for EPSDT services, and an increase of 62 percent for 10 evaluation and management services (KyHealth Choices Bimonthly Update 2007).

Other changes

In an effort to cut costs and reduce the staff complement, Kentucky contracted out several key functions in its Medicaid program to private companies, including operation of the member call center, management of provider enrollment and workshops, and management of Medicaid Operational Support Services (these changes did not require DRA authority). This process was reversed beginning in November 2008, when Kentucky Medicaid began transferring responsibility for enrolling providers, managing and updating provider lists, and hosting provider workshops from First Health to the Division of Medicaid Services (Kentucky Medicaid Provider Enrollment Website 2009). Medicaid Operational Support Services were contracted out to Accenture, a company that specializes in management consulting and technology services. Call response time with the new contractor was a major complaint for both beneficiaries and providers. According to a report by Kentucky Youth Advocates (Harris 2008), parents often faced frequent busy

tones, long waits, and inconsistent information from the customer call center.

Hopes of achieving cost savings in KyHealth Choices do not yet appear to have been realized. A state audit of KyHealth Choices in December 2007 concluded that the program has yet to realize any cost savings, despite projecting savings of \$120 million in the first year and \$1 billion over seven years. In fact, the audit found that total Medicaid expenditures had actually increased by \$42 million from 2006 to 2007. In addition, the audit recommended that the state improve its reporting practices and include more documentation of program performance. The current Medicaid Quarterly Cost Containment Reports contain projected spending levels and have no supporting documentation (Luallen 2007).

DISCUSSION

While it is too soon to draw definitive conclusions about Kentucky's Medicaid policy changes, a number of findings have emerged four years into implementation. To date, while Kentucky succeeded in meeting some of the original goals of its policy change effort, progress toward other goals has been limited. Specific goals included stretching resources to most appropriately meet the needs of members and encouraging personal responsibility for health care. This section begins by reviewing some of the successes the state has achieved and then outlines the factors that facilitated those successes. The section concludes with a discussion of the barriers the state faced that limited their progress toward achieving some goals.

Successes

Perhaps the greatest success of Kentucky's Medicaid policy changes is that the initiative demonstrated that change and innovation are possible in Medicaid when they are presented in a manner consistent with CMS policy positions. CMS approved a number of changes to Kentucky's program within a short period of time. While some of the more creative approaches proved challenging to implement in the state, several key initiatives were implemented successfully.

Kentucky succeeded in the implementation of targeted benefit packages, new copayments and soft service limits, reimbursement changes for prescription drugs and evaluation and management services, and expanded dental benefits for children. Whether the reimbursement and dental benefit changes increased the utilization of preventive and primary care services for children will be examined in future studies, as will the implica-

tions of the adoption of the targeted benefit packages, new copayments, and service limits. It is unlikely that these policy changes led to substantial reductions in emergency room visits and inpatient stays given their very limited nature. Most case study informants did not expect that the changes made to the program would have noticeable effects on costs or service use patterns. In addition, given the structure of program spending, policy changes that affect the elderly and disabled populations, which account for the majority of program costs, would be expected to have a greater impact on program costs than those targeted at children and non-disabled adults. In future policy initiatives, the state may want to focus cost containment efforts on these high-cost populations.

The enrollment simplifications and redesign of KCHIP that occurred in 2008 appeared to result in increased enrollment in that program. The upgraded MMIS and new web-based KyHealth-Net represent a step forward in terms of health information technology and use of data to inform practice procedures. This system has the potential to serve as a building block for electronic health records or future data-driven disease management initiatives in Medicaid.

Facilitators

An important factor in the initial success of the policy change process from design to early implementation was the clear vision and leadership from the governor's office and the Cabinet for Health and Family Services. However, as noted below, these elements did not enjoy bipartisan support in Kentucky, so change in the governor's office and in CHFS coincided with a slowing of the momentum for many of the proposed policy changes as priorities shifted to other areas.

Stakeholders both inside and outside Medicaid noted the increased collaboration between the Cabinet for Health and Family Services and advocacy organizations in the state. This partnership, if continued and deepened, has the potential to address environmental and social determinants of health that depend not only on state policies, but also beneficiary health behaviors.

Kentucky Medicaid also has the benefit of a health plan in the state that can serve as a testing ground for many initiatives: The Passport Health Plan in the Louisville region of the state has employed many innovative practices in disease management and care coordination (Passport Health Plan 2007), and officials in CHFS can

look to that plan for examples of what has worked well in the Kentucky context.

Barriers

Kentucky faced important barriers that inhibited the successful implementation of several key initiatives, including the Get Healthy benefits and the disease management programs. These can be grouped into four categories: organizational and personnel barriers, information barriers, financial barriers, and regulatory barriers.

CHFS is a large organization serving numerous functions, from the day-to-day operation of health and social service programs to undertaking new initiatives and projects designed to improve program performance. The pressure to fulfill daily responsibilities amid high turnover and staffing shortages may have inhibited implementation of some policy changes. KyHealth Choices attempted to address the staffing shortages by contracting out some administrative responsibilities, but implementation problems with contractors left the claims administration system functioning below expectations and resulted in responsibility for the diabetes disease management program being shifted to the Department for Public Health.

Lack of strong leadership and clear direction for the disease management programs and political and geographic issues over where to locate the pilot sites also contributed to implementation problems with these programs. Given the low intensity of the disease management programs that were implemented and the fact that the Get Healthy benefits were not implemented at all, it is unlikely that this effort could have achieved its objectives of promoting healthier behaviors among enrollees and containing program costs. As few states have experience with personal health benefits in Medicaid, little is known about how to structure them to maximize their impact. Nevertheless, existing research has found there is little success with low-intensity or one-time rewards (Christianson 2007; Jepson et al. 2000; Kane et al. 2004; Redmond et al. 2007). In designing future initiatives, the state may wish to explore higher-intensity programs that may have greater success at changing enrollee behavior (Donatelle et al. 2004).

In addition, effective strategies for communicating with beneficiaries will be important in future policy change efforts, particularly those that require a change in enrollee behavior. The rules for new cost-sharing requirements and service limits may not have been effectively communicated to enrollees given their reports of confu-

sion over the application of the new policies to specific individuals and services.

Kentucky does not have a mechanism for tracking evidence-based quality of care standards for its KenPAC providers (for example, influenza vaccination and cancer screening rates). Collecting more data on KenPAC providers with regard to their patients' service use patterns and health outcomes could facilitate real-time feedback and improve service quality. For example, monitoring emergency room use patterns and rates of ambulatory care sensitive admissions separately for subgroups of beneficiaries and individual KenPAC providers could help the state devise policies that would reduce unnecessary hospital and emergency room use. Updating and modifying the MMIS system to allow routine production of service use and spending reports is one way to move toward that goal. Investing in electronic health records could also yield important gains in this area.

While KyHealth Choices remains fully funded during the current economic crisis due to an enhanced federal matching rate, lack of discretionary funds will create financial barriers for new initiatives. It is unlikely that policy changes such as the Get Healthy benefits, additional disease management programs, or new initiatives by the current administration would be implemented in the near future as a result of limited funding streams.

Many in the state also expressed frustration working with CMS to approve their policy changes. There was a perceived lack of policy continuity over time and across departments within CMS, making it difficult for policy makers in the state to design new policy initiatives. For example, CHFS spent many months in communication with CMS trying to get approval for the Get Healthy benefits, which were already approved for use in other states. Those who were shepherding the proposals

through CMS reported receiving mixed messages, at times being told that proposed policies fell within the guidelines of the DRA and at other times told they did not. Greater coordination of vision and policy goals both within CMS and between CMS and the states could have eased the burden on getting new initiatives approved.

Kentucky's ambitious policy agenda and early leadership from the governor and the Cabinet for Health and Family Services enabled the state to implement some policy changes effectively within the original timetable. While these policy changes may have laid the groundwork for changing the way the Medicaid program delivers care, key informants in the state did not perceive that the implemented changes addressed the root sources of access, cost and quality problems in Medicaid and therefore did not expect the policy changes to lead to noticeable changes in these areas. However, there was a perception that the policy changes may have stimulated greater access to dental care for children. Stakeholders identified a number of additional policy issues that would need to be addressed in order for the Kentucky Medicaid program to achieve the goals it set out to achieve: controlling program costs and promoting healthy behaviors among its non-elderly enrollees. Issues that were mentioned included the absence of Medicaid coverage of benefits for substance abuse treatment, smoking cessation services, and family planning services; the fragmentation in financing between inpatient and outpatient mental health services; provider capacity issues; and inefficiencies with regard to the distribution of health care resources. The future direction of the Medicaid program will depend in part on how the state weathers the current economic storm and on the policy changes that accompany federal efforts to reform the health care system.

TABLE 1. TIMELINE OF POLICY IMPLEMENTATION

<p>May 2006</p> <ul style="list-style-type: none"> • May 15 is official implementation date of policy changes. Commissioner Sharon Turner sends letter to providers informing them of the new targeted benefit plans
<p>June 2006</p> <ul style="list-style-type: none"> • Co-payments and soft service limits begin
<p>September 2006</p> <ul style="list-style-type: none"> • 15th-Prior authorization requirements come into effect • (Date of service) 30th-Second comprehensive oral exam/year becomes available for members under 21; 30 percent increase in dental provider fees goes into effect for some procedures (members under 21) • Third tier pharmacy benefits become more generous
<p>October 2006</p> <ul style="list-style-type: none"> • Service limit of 26 visits/year imposed on adults
<p>December 2006</p> <ul style="list-style-type: none"> • Nicotine replacement therapy becomes available to members who use the Kentucky Tobacco Quit Line (via partnership between Department of Medicaid Services, Department of Public Health, and “Get Healthy Kentucky”)
<p>February 2007</p> <ul style="list-style-type: none"> • Initiation of Medicaid Management Information System (MMIS) is postponed
<p>June 2007</p> <ul style="list-style-type: none"> • 4th MMIS is launched
<p>July 2007</p> <ul style="list-style-type: none"> • Provider fees increase for evaluation and management codes
<p>November 2008</p> <ul style="list-style-type: none"> • Face-to-face interview eliminated for enrollment and re-determination of children

TABLE 2. KYHEALTH CHOICES DISEASE MANAGEMENT INITIATIVES

Target	Counties*	Patients	Providers	Notes
Breast and Cervical Cancer Screening	<i>Breathitt, Elliott, Floyd, Johnson, Lawrence, Powell, Magoffin, Martin, Wolfe</i>	Missing data	Missing data	
Congestive Heart Failure	<i>Clay, Fayette, McCreary</i>			Put on hold in early 2006 due to Pfizer initiative below
Pfizer Healthy at Heart	All but Passport counties	Missing data	Missing data	
COPD/Adult Asthma	<i>Letcher, Perry, Whitley</i>	1821	138	
Diabetes	<i>Bell, Floyd</i>	1281	53	
Pediatric Asthma	<i>Perry, Pike, Powell</i>	3117	65	
Pediatric Obesity	<i>Christian, Fayette, Pike, Warren</i>	534	246	
Prostate Cancer Screening	<i>Boyd, Clinton, Laurel, Rockcastle</i>	2720	485	Awareness: "Consult your PCP"
Minority Health	<i>Christian, Daviess, Fayette, Kenton, McCreary, Madison, Warren</i>	1314	5109	
Pediatric Diabetes (I and II)	<i>Bell, Floyd, Perry, Pike, Warren</i>	254	Unknown	
Adult Obesity	<i>Fayette, Knox, Pike, Warren</i>	2299	None	Under development
Osteoporosis	<i>Campbell, Graves, Greenup, Hopkins</i>	2645	None	
Coronary Artery Disease	All but Passport	64,847 (ages 35-50)	None	Single postcard

*Appalachian counties are indicated in *italics*.

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NOTES

- ¹ The project also examines DRA-related changes in Idaho.
- ² Federal law requires that states cover these groups only up to 133 percent of the FPL.
http://www.cms.hhs.gov/MedicaidEligibility/03_MandatoryEligibilityGroups.asp#TopOfPage
- ³ Federal minimum income levels are 133 percent of the FPL for children under 6 and 100 percent of the FPL for children ages 6-18. http://www.cms.hhs.gov/MedicaidEligibility/03_MandatoryEligibilityGroups.asp#TopOfPage
- ⁴ The American Recovery and Reinvestment Act of 2009 provided a temporary increase in the federal matching rate of 6.2 percentage points, plus additional increases based on the increase in the unemployment rate in each state. The Government Accountability Office estimates that this will result in an additional \$1.03 billion in federal funds to Kentucky between FY2009 and FY2011 (Kaiser Commission on Medicaid and the Uninsured 2009).
- ⁵ Another 2 percent of enrollees are in an unknown age category (Kentucky MS-264 data 2007)
- ⁶ The state spends another 1 percent of total spending on enrollees whose eligibility group is unknown (Urban Institute/Kaiser Commission on Medicaid and the Uninsured 2009).
- ⁷ The 17 percent estimate is derived by dividing the 140,626 members in Passport (<http://www.passporthealthplan.com/about/>) by the 844,700 total Medicaid enrollees (Urban Institute/Kaiser Commission on Medicaid and the Uninsured 2009).
- ⁸ KyHealth Choices also gives members needing long term care Consumer-Directed Options and Self-Directed Options for managing their care. This change is intended to help members stay integrated into the community if they so choose, rather than move to an institutional setting. Another reform was the integration and coordination of Kentucky's mental health/mental retardation service delivery system across all regions of the state to ensure that members with mental health problems, mental retardation, and substance abuse problems have access to the same services within the state. The pre-reform system was fragmented in terms of services available, provider networks, and financing across the different regions in the state. Members in all regions were to have access to a core set of services, but individual regions would be allowed to offer additional services as needed by the populations they serve. Physical health services were also to be coordinated with the other services.
- ⁹ These excepted conditions include hemophilia; HIV/AIDS; dementia; psychotic, schizophrenic, schizotypal personality, and bipolar disorders; acute therapy for migraine headaches; cancer; epilepsy; coronary artery/cerebrovascular disease; hyperlipidemia; hypertension with co-morbid type 2 diabetes with nephropathy or systolic heart failure; cardiac rhythm disorders; diabetes; metabolic syndrome; end stage lung and renal disease; organ transplant; terminal stage of an illness; and cystic fibrosis.
- ¹⁰ Kentucky's original 1115 waiver proposed allowing parents of children enrolled in Medicaid or KCHIP to buy into Medicaid by paying the difference between the child-only premium and the family premium (Health Management Associates 2006). This proposal was not approved by CMS, reportedly out of concern that the state had not covered a sufficient share of low-income uninsured children to justify expansion to parents.
- ¹¹ Infants are covered under Medicaid up to 185 percent of the FPL, so only infants with family income between 185 and 200 percent FPL are enrolled in KCHIP.

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SHARE is a national program of the Robert Wood Johnson Foundation and is located at the University of Minnesota's State Health Access Data Assistance Center (SHADAC).

The SHARE project has the following key goals:

1. Coordinate evaluations of state reform efforts in a way that establishes a body of evidence to inform state and national policy makers on the mechanisms required for successful health reform.
2. Identify and address gaps in research on state health reform activities from a state and national policy perspective.
3. Disseminate findings in a manner that is meaningful and user-friendly for state and national policy makers, state agencies, and researchers alike.

To accomplish these goals, SHARE has funded 16 projects covering 29 states.

CONTACTING SHARE

The State Health Access Reform Evaluation (SHARE) is a Robert Wood Johnson Foundation (RWJF) program that aims to provide evidence to state policy makers on specific mechanisms that contribute to successful state health reform efforts. The program operates out of the State Health Access Data Assistance Center (SHADAC), an RWJF-funded research center in the Division of Health Policy and Management, School of Public Health, University of Minnesota. Information is available at www.statereformevaluation.org.

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