United Methodist HealthMinistryFund

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Sarah Fertig
State Medicaid Director
Division of Health Care Finance
Kansas Department of Health and Environment (KDHE)
900 SW Jackson St., 9th Floor
Topeka, KS 66612

Dear Director Fertig:

As the state of Kansas begins the competitive reprocurement process for the state's Medicaid managed care program, KanCare, I am writing to share ideas to stimulate innovations that could improve the program. With nearly 500,000 KanCare members, the reprocurement process for KanCare 3.0 offers an opportunity to improve the health and experience of enrollees.

The United Methodist Health Ministry Fund's mission is to improve the health of all Kansans. Our three areas of focus are: Access to Care, Thriving Children and Engaged Congregations and Communities. This set of comments is focused on Maternal and Child Health issues and builds on previous comments related to the reprocurement process and rural workforce issues.

During the past several years, we have appreciated opportunities to partner with the Kanas Department of Health and Environment (KDHE) on improving our state's Medicaid program, particularly on issues related to addressing the social and emotional health and development of very young children, birth to age 5. Our collective efforts have focused on the important role of pediatric primary care in providing support and guidance to caregivers on how they can nurture early brain development during their baby's most rapid and vital period of growth. Together, we also have been exploring policies to establish Medicaid coverage for non-licensed professionals such as Community Health Workers; this joint effort is still underway.

As Kansas implements the extension of postpartum Medicaid coverage from 60 days to 12 months – a very important advance – we strongly encourage KDHE to build on that knowledge and experience and elevate activities that safeguard the health of the caregiver-infant pair (the "dyad") in the KanCare 3.0 RFP and contract. Some of the language offered in this memo reflects our previous conversations, particularly related to maternal depression screening and more recently on extended care team members, including community health workers, doulas, lactation specialists and peer navigators.

Improving Care for KanCare Enrollees

Throughout the public comment process, we have emphasized that the Medicaid Managed Care contract is itself a powerful instrument for securing adherence to state priorities. As a starting point, KDHE can set high expectations for quality and innovation, leveraging the procurement process to reward proposals that demonstrate an understanding of how to achieve improved care through investments in innovative and evidence-backed approaches. Rewards can include "extra points" toward a successful bid or a preference in auto-assignment of Medicaid enrollees who do not indicate a preferred plan. KDHE could flag quality improvement targets or its increased interest in seeing greater

community engagement on the part of MCOs and clearly indicate what will be expected of successful bidders.

Financial incentives that can be leveraged through the Medicaid MCO contract include:

- **Performance Improvement Projects (PIPs)** that aim to achieve improvements on both Medicaid and CHIP Child Core Set Quality Measures, as well as the Maternity Core Set. States may tie the results of the PIPs to a boost (or, alternatively, a withhold) in payment. KDHE may leave up to the MCOs the health care measure(s) to be improved. In addition, KDHE may require all MCOs to undertake at least one cross-plan PIP designed to significantly improve a pre-selected metric statewide. Later in the comments, we will offer examples of PIPs employed by other states and offer additional ideas on potential PIPs.

- **Medical Loss Ratio (MLR).** KDHE and the public have a strong interest in getting the most out of the MCOs' total capitated (per-enrollee) payments spent on improving health outcomes. Kansas requires the minimum for Medicaid MCOs, 85 percent (although it could increase the share of total capitated payments required to 88 percent or even higher.) KDHE could establish stronger, more consistent enforcement mechanisms, (e.g., requiring MCOs to pay back the difference between the state's designated MLR and the MCO's.)

- Alternatively, KDHE could permit MCOs that do not meet the minimum MLR to allocate a portion of the total remittance toward specific activities, such as quality improvement or activities to strengthen partnerships with community organizations or clinics. The MCOs would be allowed to count all or a portion of the associated costs towards its MLR calculation, helping them get closer to 85 percent or exceed that level. At the same time, the communities and KanCare enrollees in those communities would benefit from the new or strengthened partnerships.

High expectations for high quality maternal and child health

Improving the health and well-being of mothers, infants and children is critically important, especially as it significantly influences the health and well-being of the next generation. Maternal and child health status may be an early indicator of future public health challenges for families, communities, and the health system. Unfortunately, significant racial disparities exist in maternal and child health that undermine the future prospects of children of color.

One major concern, for example, is that behavioral health care – especially preventive services for children often are overlooked -- even though Medicaid's EPSDT benefit for children includes behavioral health screenings and treatment.

To send an initial signal on its expectations for change, the RFP can require KanCare 3.0 bidders to respond to questions that would encourage them to focus on and distinguish their proposals based on how they plan to address issues related to improving Maternal and Child Health, including integrated physical/behavioral health care.

For example:

- Given Kansas' extension of Medicaid coverage to 12 months post-partum, what will you do to ensure a robust set of benefits are available to this group, including connections to WIC services and other public benefits key to the health of caregivers and children?
- Describe how you will ensure a two-generation approach to care, including "dyadic care" to address behavioral health issues?
- What outreach mechanisms will you use to ensure that families know about new coverage and services?
- How will you make doula services available, especially in rural communities? What about other "new" care team members, including community health workers, peer navigators, lactation specialists, etc.?
- How will you ensure that pediatric medical homes are the central focus of care for children and families and that attention is paid to expanded care teams?
- How will you ensure comprehensive screening and effective referrals for health-related social needs?
- What value-added services will you offer to contribute to addressing health-related social needs?
- How will you forge meaningful partnerships with community organizations to address health-related social needs?

Alternatively, any or all of these questions could be fleshed out to require or encourage MCOs interested in delivering KanCare services to take specific actions.

Below please find the Health Fund's recommendations for improving MCH care, along with sample MCO contract language from other states.

<u>Adopt and encourage use of dyadic care through contracting process</u>

Dyadic services support children and their parents/caregivers at the same time and strengthen foundational relationships, which support healthy development and long-term health. In Kansas, nearly 20% of Kansas women below 200% of the federal poverty level experienced postpartum depression in the year after giving birth. Beyond long-term benefits of dyadic care, this approach can be helpful in addressing maternal depression.

To address postpartum depression and to improve long-term health, we urge KDHE to consider adopting a Dyadic Care (Caregiver/Infant) approach, especially in pediatric practices that are implementing the state's Maternal Depression Screening policy, and with special attention paid to providers caring for individuals covered under the postpartum extension (60 days to 12 months.)

Kansas is among the majority of states to adopt a payment policy for Medicaid coverage of caregiver/postpartum depression screening as a component of pediatric primary care. Given the strong link between maternal mental health and the child's healthy development (social, emotional, cognitive, etc.) KDHE should adopt and implement a "dyadic care" (i.e., a "two generation care") approach so that a positive depression screen (for example) does not go untreated, increasing risks for both the parent/caregiver and the child, and higher costs for the state. KDHE should clarify that EPSDT rules require states (and MCOs) to address the results of EPSDT screens that indicate a potential or actual problem exists.

The contract can include a payment policy to support the health of the child/caregiver relationship, utilizing a model of "two-generation" care. Note that these examples also demonstrate that Medicaid can cover certain behavioral health services without a diagnosis – illustrating the importance of providing the full range of EPSDT services and recognizing that preventive behavioral care should be included. For example:

> **California:** Clarified statewide guidance to permit children with at least one risk factor (e.g., food insecurity, discrimination, separation or death of a parent) to receive family therapy, and children without a risk factor may receive up to five sessions of individual or family therapy before a behavioral health diagnosis is required for "two-generation" care.
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> **Massachusetts:** Allows children under age 21 to access up to six preventive behavioral health sessions if they screen positive in a behavioral health screening, regardless of whether or not they meet diagnosis criteria; for infants, screening many include a caregiver's post-partum depression screening. (Colorado has a similar policy and approach.)
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> **Maryland:** Initiated new policies to support dyadic care as key to healthy pregnancies and the health of the parent/caregiver and child through the first few years of life. Policies allowing Medicaid coverage for models such as "Centering Pregnancy" and "Healthy Steps" are in effect and a policy transmittal was issued to Managed Care Organizations; OBGYN, Pediatric and Family Medicine Physicians and Nurse Practitioners; and Nurse Midwives. KDHE should follow Maryland's lead, and integrate the dyadic care payment policy into its Medicaid managed care contract.

Improve and expand use of the care team and alternative providers, including non-licensed, credentialed providers.

Kansas, like other states, is struggling to sustain a robust health care workforce. In order to build the capacity of the team in Kansas, the state should continue to explore how Medicaid can sustain non-licensed credentialed team members as a workforce strategy. Kansas can strengthen care delivery by prioritizing diverse teams that allow all team members to practice to the top of their scope of practice, including non-licensed credentialed providers who can offer services in community settings. Medicaid payment policy and managed care contracting language are critical to supporting and sustaining this workforce.

We have been fortunate to partner with KDHE to advance the practice of community health workers through credentialing and payment policy. In tandem with pursuing the state plan amendment, Kansas could explore how to leverage the MCO contracting process to support CHWs.

We encourage KDHE to require and/or incentivize MCOs to engage/contract with community health workers to improve identified health disparities and preventive/primary care.

> **Michigan:** The State requires MCOs to "support the design and implementation of community health worker interventions delivered by community-based organizations which address social determinants of health and promote prevention and health education."
> The State leverages the MCO contract to require MCOs provide one community health worker per 5,000 enrollees. The State incentivizes MCOs to contract with CHWs at

clinics and community-based organizations by counting CHWs at clinics and community-based organizations as 1.25 FTE instead of 1.0 FTE for the purposes of the required ratio. Community health workers provide home visits, support in coordinating medical visits, accompany members to medical office visits, and arrange for social services and supports.

New Mexico: The State requires MCOs to share or delegate care coordination to a variety of entities or individuals, including community health workers. New Mexico further leverages its "Delivery System Improvement Performance Target" framework, which imposes financial penalties for failure to meet the targets of:

- at least 3% of MCO's enrolled members being served by community health workers, CHRS, and/or CPSWs annually, and
- at least a 10% increase in MCO's enrolled members being served over the 5-year period.
- **MCOs have the option** of proposing a plan, subject to State approval, to re-invest financial penalty amounts on system improvement activities. Community health workers provide education, outreach, counseling, support services, advocacy, translation services, and care coordination assistance.

As KDHE finalizes its efforts to implement a payment policy and strategy for community health workers. We also recommend **expanding the Pediatric Primary Care Team to include** additional non-licensed providers, including doulas, lactation specialists, community paramedics/EMTs, peer navigators, etc.

Pediatric primary care providers, children, and families can be supported by expanding pediatric primary care teams with culturally appropriate providers and home visitors who provide community supports and services to individuals. Kansas' MCO contract could encourage an expanded care team to address social drivers of health and coordinate with the state's home visiting programs, including those administered with Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funds. The State can leverage the Medicaid MCO contract to strengthen pediatric primary care teams by requiring or incentivizing the deployment of community health workers or implementation of home visiting programs for young children. Examples of contract language include:

Louisiana: 2.7.11. Multi-Disciplinary Care Team. 2.7.11.1. The Contractor shall identify a multi-disciplinary care team to serve each enrollee based on individual need for all enrollees in case management Tiers 2 and 3 and transitional case management. The contractor shall assign lead case managers based on an enrollee's priority care needs, as identified through the individual care plan. Where behavioral health is an enrollee's primary health issue, the case manager shall be a behavioral health case manager. As needed, case managers with expertise in physical or behavioral health care will support lead case managers where there are secondary diagnoses. If the enrollee is under the age of six (6), the lead case manager shall have expertise in early childhood mental health or access to a consultant with expertise in infant and early childhood mental health…. Potential team members shall include but are not limited to: 2.7.11.3.1. Primary care provider; 2.7.11.3.2. Behavioral health provider(s); 2.7.11.3.3. Specialist(s); 2.7.11.3.4 Pharmacist(s); 2.7.11.3.5. Community health worker(s); 2.7.11.3.6. Peer specialist(s); 2.7.11.3.7. Housing specialist, if the enrollee is identified as homeless; and 2.7.11.3.8. State staff, including transition coordinators. Louisiana Medicaid Managed Care Model Contract, pp. 96-97

Michigan: Services Provided by Community-based Organizations. "Contractor must, to the extent applicable, support the design and implementation of Community Health Worker (CHW) interventions delivered by community-based organizations which address Social Determinants of Health and promote prevention and health education, and are tailored to the needs of community members in terms of cultural and linguistic competency and shared community residency and life experience."

Pennsylvania: Community-based Health Care Program. I. Community Based Care Management (CBCM) Program Requirements…. D. CBCM activity can involve care coordination by licensed and non-licensed team members as defined by the latest version of the Operations report. Emphasis should be placed on expanding the use of non-licensed professionals to focus on face-to-face interaction with members. Examples of licensed providers include but are not limited to: physicians, dentists, dental hygienists, public health dental hygiene practitioners (PHDHPs), physician's assistants, Certified Registered Nurse Practitioners (CRNPs), nurse midwives, RNs [Registered Nurses], LPNs [Licensed Practical Nurses], MSWs [Medical Social Workers], dieticians, psychologists, and pharmacists. Examples of non-licensed team members include but are not limited to: medical assistants/technicians, community health workers, doulas, paramedics/EMTs, faith-based ministries, and peer specialists.

Require improved data collection and reporting to measure outcomes and utilization

To better measure outcomes and utilization, we recommend KDHE to require MCOs to publicly report quality measures of child health and adult behavioral health by race and ethnicity and service location (region, plan, provider.)

At the federal level, in 2024, CMS will require state Medicaid and CHIP agencies to report all health care quality measures for children (Child Core Set) and the behavioral health measures for adults (Adult Core Set for Medicaid). Requiring MCOs to collect and report core set measures disaggregated by race/ethnicity and service location for children ages 0-3 would provide data needed to track progress in the state's effort to address disparities.

Louisiana: The Contractor shall ensure that data collection, data systems, and analysis allow for the identification of disparities by Enrollee characteristics. As directed by LDH, the Contractor shall stratify and annually report on quality measures by race, ethnicity, language, geographic location (urban/rural parish) and/or by disability in a format provided by LDH….LDH may publicly share these stratified results, including comparing performance across MCOs, over time, and to state and other available benchmarks. For CY2023, Attachment H: Quality Performance Measures requires specific quality measures to be stratified by race/ethnicity and rural/urban status:

- Pregnancy: Percentage of LBW Births, Contraceptive Care –Postpartum Women Age21–44
- Child: Well Child Visits in the First 30 Months of Life, Childhood Immunizations (Combo 3), Immunizations for Adolescents (Combo 2)

- Adult: Colorectal Cancer Screening, HIV Viral Load Suppression, Cervical Cancer Screening

- Behavioral Health: Follow-Up After Emergency Department Visit for Mental Illness (within 30 days), Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (within 30 days), Follow-Up After Hospitalization for Mental Illness (within 30 days).

The Contractor's Health Equity Plan must ...Stratify Contractor results on certain quality measures to identify/address disparities.

Missouri: 2.23.12 Adult and Child Core Sets Reporting – The health plan shall submit a report on Adult and Child Core Sets that reflect results stratified by several categories: gender, age group (as defined in each measure's specifications), race, ethnicity, and region (urban/rural). The Adult and Child Core Sets Reports shall be submitted in the format and frequency specified by the state agency at the Adult and Child Core Sets Report located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates.

Strengthening EPSDT

EPSDT is a critical benefit to ensure appropriate preventive, dental, behavioral health, developmental, and specialty services are provided to children enrolled in Medicaid. The current Kansas MCO contract includes some details on the EPSDT benefit, but can be improved to strengthen oversight, monitoring, and quality outcomes for Kansas' MCOs, as well as support pediatric primary care providers enrolled in Kansas' Medicaid program in understanding the EPSDT benefit and their responsibilities.

•Modify the pediatric child health metrics MCOs must report to include developmental screenings and maternal depression screenings and publish the MCO-specific data regularly – stratified by race, ethnicity, language and geography (to analyze data for rural areas) for families to review when selecting an MCO.

While reprocurement of the Medicaid managed care contract offers the opportunity to demonstrate new ideas and approaches, the process also calls for taking the time to **clarify existing rules and policies** and make warranted adjustments. Areas of confusion around definitions and rules include:

Medical Necessity:

- **New Hampshire:** The State's MCO contract defines "medically necessary" and "medical necessity determination":

    - Medically Necessary: "Per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Members under twenty-one (21) years of age, "Medically Necessary" means any service that is included within the categories of mandatory and optional services listed in Section 1905(a) of the Social Security Act, regardless of whether such service is covered under the Medicaid State Plan, if that service is necessary to correct or ameliorate defects and physical and mental illnesses or conditions."

- Medical Necessity Determination: "For Members under twenty-one (21) years of age, per EPSDT, the following definition of medical necessity shall be used: "Medically Necessary" means any service that is included within the categories of mandatory and optional services listed in Section 1905(a) of the Social Security Act, regardless of whether such service is covered under the Medicaid State Plan, if that service is necessary to collect or ameliorate the defects and physical and behavioral illnesses or conditions."

Care coordination

As part of our ongoing discussions with stakeholders on how we can improve KanCare, care coordination regularly comes up as part of the discussion. As part of the reprocurement process KDHE can clarify language around explicit expectations as it relates to care coordination.

Federal rules regarding Medicaid Managed Care Plans' obligations to deliver care coordination to all enrollees are a case in point. These rules have been a source of confusion and concern, especially when it comes to the needs of children who do not have intensive or complex physical or behavioral health needs. There also may be confusion about who can conduct care coordination services.

In very young children, developmental delays or other needs that could be addressed effectively through Early Intervention may not become apparent until proper screenings have been performed and the child has been referred for further assessment. Virginia's Medicaid Managed Care Contract assures that very young children found to have developmental needs have access to targeted case management services delivered by an individual who understands Early Intervention services. The Virginia managed care contract language follows:

> **Virginia:** Medallion 4.0 Managed Care Contract [2018], pp. 142-143 Early Intervention Targeted Case Management/Service Coordination: The Contractor shall provide coverage for EI Targeted Case Management (also referred to as EI Service Coordination). EI service coordination is a service that will assist the child and family in gaining access to needed and appropriate medical, social, educational, and other services. EI Service Coordination is designed to ensure that families are receiving the supports and services that will help them achieve their goals on their child's Individual Family Service Plan (IFSP), through monthly monitoring, quarterly family contacts, and on-going supportive communication with the family. The Service Coordinator can serve in a "blended" role; in other words, a single practitioner can provide both Early Intervention Targeted Case Management/Service Coordination and an IFSP service, such as physical therapy developmental services, etc. to a child and his or her family.

Cross-plan EPSDT PIP

In addition to strengthening EPSDT benefits through contract language, Kansas could consider a **cross-state PIP focused on EPSDT.** For example, the State requires MCOs with an EPSDT 416 rate below 85% to implement a performance improvement plan (PIP) to address EPSDT screening and outreach – currently, all three of Kansas' MCOs have an active EPSDT PIP.

As part of the reprocurement process, Kansas should ask bidders to demonstrate that activities conducted to support performance improvement are backed by evidence, and there should be a plan to collect and report data on progress achieved.

- **Oregon:** All Coordinated Care Organizations (CCOs) are required to participate in a single, statewide PIP focused on integrating primary care, behavioral health, and/or oral health. CCOs are also required to select at least three additional PIPs from a list of seven (pediatric and equity related PIPs from this list include: improving perinatal and maternity care; improving primary care for all populations; Social Determinants of Health and Equity), resulting in each CCO participating in a minimum of four annual PIPs (with one statewide).

- **New York:** First 1,000 Days on Medicaid's Kids Quality Agenda requiring participation and collaboration from all MMC plans on a two-year common PIP focused on children's and perinatal quality measures focused on: (1) increasing performance on young child related Quality Assurance Reporting Requirements (QARR) measures (e.g., well-child visits, lead screening, child immunization combo); enhancing rates of developmental, vision, hearing, and maternal depression screenings and/or evaluations; and improving select performance on existing QARR perinatal health measures.

- NYS MCOs have published details on the 2019 – 2021 Kids Quality Agenda PIP including a focus on (see Affinity Health Plan and MVP Health Care) blood lead testing and follow-up;
- Newborn hearing screening and follow-up; and
- Developmental screening.

To encourage MCOs to adequately invest in the Kids Quality Agenda PIP and outcomes (well-child visits in first 15 months, timeliness of prenatal care, and postpartum care), MCOs that are in the 90th percentile on all outcome measurements will be provided one additional measure worth of points (currently 3.03 points).

Social determinants of health

Social determinants of health (SDOH) are the social and economic conditions under which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks. Social and structural factors play a critical role in driving disparate health outcomes. One study estimated that, on average, clinical care impacts only 20 percent of county-level variation in health outcomes, while SDOH affect as much as 50 percent of health outcomes.

Medicaid programs have been developing strategies to identify and address enrollee social needs both within and outside of managed care. CMS released guidance for states about opportunities to use Medicaid and CHIP to address SDOH in January 2021

As KDHE explores how to address SDOH and improve the health of Kansans, there is an opportunity strengthening the state's existing Social Determinants of Health and Independence program, value-added benefits, and/or "in lieu of services" (ILOS) to address social and economic drivers of health for families enrolled in Medicaid. Here are examples from other states:

- **Colorado:** The State contract requires plans to establish relationships and collaborate with economic, social, educational, justice, and recreational organizations that promote the health

and well-being of the community; school districts and schools to coordinate care and develop programs to optimize the growth and well-being of children enrolled in Medicaid; and partner with community-based organizations providing resources such as food, housing, energy assistance, childcare, education, and job training.

- **Rhode Island:** The State included an attachment in the MCO contract for pre-approved ILOS identified by the State, including Meals on Wheels-Meal delivery, medically appropriate smart phone applications, and nutritional programs for weight reduction, therapeutic counseling, and group support programs.

Promising Innovative Approaches

As noted, Medicaid managed care contracts are a powerful tool that can be used to set forth state priorities for improved care delivery and for monitoring progress or the need for mid-course corrections. In addition to the specific contracting strategies we have recommended in this memo, there are a few overarching innovations worth considering as KDHE moves forward with the KanCare3.0 procurement process. Executing these ideas may entail time and research and stakeholder engagement beyond the scope of this memo. In addition, as you are aware, the US Department of Health and Human Services has issued proposed regulations on Managed care and on assuring access for Medicaid and CHIP enrollees. Ideas such as improvements in the way Beneficiary Advisory Groups are implemented are prominently featured in those regulations. As it will take time for those proposed regulations to be finalized at the federal level, we would welcome the opportunity to work with you to ensure that Kansas is in the vanguard on stakeholder and family engagement.

Here are three innovations we offer for your consideration:

High Performing Family-Centered Medical Homes: This would build on ideas discussed elsewhere under which KDHE (and stakeholders) could design the elements of a Family Centered Medical Home that would have a two-generation focus. The "pioneering" practices could be required to include all or a subset of the key features and would be rewarded with a bump in payment if performance on specific quality metrics met or exceeded predetermined targets.

Minimum Pediatric Primary Care Spend: Often pediatric primary care is not high on the priority list for health care payors and providers. However, if "prevention is paramount" ensuring that primary care has sufficient resources is essential. Some states are addressing this problem by requiring a specified portion of the capitated payments to be allocated for pediatric primary care.

- **Family Advisors:** As noted, this topic will be covered in new regulations that are still in the process, however, this does not preclude KDHE and its stakeholders from getting started on this very important idea that could do much to advance equity and improve care.

Thank you for the opportunity to share our thoughts as part of the reprocurement process. Should you have any questions, please let me know.

Sincerely,

David Jordan