Heading into the 2011 Legislative Session, Kentucky faced a $139 million gap in the Medicaid budget for the current fiscal year. The gap exists because the General Assembly assumed the federal government would allot Kentucky $100 million more in stimulus funds for Medicaid than what Congress later approved. Additionally, the administration was counting on saving $125 million in Medicaid in 2011 through implementing cost-saving strategies, such as reducing unnecessary use of medical services, treatments and emergency room visits, but was only able to save $86 million. To solve the shortfall dilemma and avoid detrimental cuts, the House and the Senate agreed to a plan which both moves money from the 2012 budget to 2011 and saves money through implementing Medicaid managed care.

With legislation to balance the state’s Medicaid budget finalized, state administrators now have the task of implementing a cost-effective and high-quality model for managed care to serve Kentucky’s low-income families. If the plan fails to save the state dollars, then Kentucky’s children and families could suffer the consequences as policymakers implement broad and deep cuts to needed supports.

Managed care itself can be a high-risk proposition. The national experience with managed care is as diverse as the nearly three dozen states that use a managed care system to deliver care. In some cases, managed care produced dramatic savings and improved health outcomes. In other cases, the reverse occurred. Advocates are calling on policymakers to carefully explore the impact of any managed care option before it becomes a reality. Health and child advocates play a key role in ensuring this takes place by sharing concerns and opportunities for the groups they represent with decision-makers and managed care providers who are interested in working in Kentucky.

What is managed care?
Managed care is a cost-savings approach to delivering health care services which aims to improve the quality and coordination of care and increase access to care. It does so by ensuring that those enrolled in the program have a primary care provider, and that the enrollee relies mainly on preventive and primary care, rather than emergency care. Managed care organizations provide a specific package of health care benefits with a specific list of providers. They also provide financial incentives for program enrollees to use providers and services within the organization and for providers, who receive payment up front.
State Medicaid agencies contract with managed care organizations that agree to provide services for a prepaid, or capitated rate, or arrange for the services to be provided. This means that the managed care organizations receive money from the state Medicaid agencies and then pay a predetermined amount, usually monthly, to primary care providers. The provider serves as the gatekeeper and coordinates health care services needed by individuals under contract terms. This differs from traditional fee-for-service systems where more care results in more income, which is how the majority of states run Medicaid. Instead, the prepayment of a set amount ideally provides incentives for the provider to avoid unnecessary services and to invest in preventive care.

States are adopting managed care systems based on the assumption that it will reduce costs while improving health outcomes. Opponents argue the cost-saving strategies used by managed care companies could compromise the well-being of plan members by making it more difficult to navigate an already complex health care system. Because of the potential for specific regulations and rules to be put in place, it could become even more difficult for an individual covered by Medicaid managed care to find physicians who will treat them.

**Managed care and children**
Kentucky currently contracts with the managed care organization, Passport Health, to provide Medicaid services in Jefferson County and 15 surrounding counties and is seeking to expand managed care across the state to save money. This statewide shift will impact 430,000 children currently covered by Medicaid and the Kentucky Children’s Health Insurance Program (KCHIP). Research indicates that certain aspects of the managed care contracts matter more to the well-being of children than others. Contracts are crucial to ensuring benefits for children because they represent the sum total of the health care children will receive under Medicaid and KCHIP. Policymakers negotiating these contracts need to pay attention to the following:

- Benefits provided for children specified in contracts;
- State’s monitoring of whether the managed care organizations are meeting the contract specifications;
- Contract enforcement;
- Access to patient protections; and
- Performance incentives aimed at improving quality of care.

While managed care could translate into improved access to care, concerns may arise if plan or provider participation is inadequate, eligibility for Medicaid is unstable, or the unique needs of the Medicaid population are overlooked, particularly for children. While Kentucky is moving to managed care because it aims to save the state money, the research on this topic shows mixed results on both savings and access to care. Some studies show improved access to services and a reduction in hospitalization. Other studies, however, indicate worse results.

Foreseeable problems could arise as the state moves to implement expanded managed care. One example of this is as the state rolls out a new system there could be interruptions in the Medicaid/KCHIP enrollment process. This should be avoided as either a cost saving measure or as a side effect of the transition to a new system. It is also important to ensure adequate payment for managed care programs so enrollees have access to necessary and appropriate care when they need it. Federal Medicaid rules require capitation rates to be “actuarially sound.” This means the rates must be high enough to ensure that plans can provide appropriate access and care for program participants. While these problems are true for the entire Medicaid population – children are even more vulnerable to lapses in coverage because of their constantly changing developmental needs and the importance of consistent health coverage for both prevention and treatment of chronic conditions. Understanding how Kentucky plans to monitor managed
care systems will help advocates determine how to ensure the quality and accessibility of care for children enrolled in Medicaid and KCHIP.13

Managed care and children of color
All children in Kentucky need quality health care in order to grow up healthy and reach their potential. Historical patterns of unequal treatment have led to racial and ethnic disparities in health outcomes. One promising strategy is to adopt a quality improvement framework to promote measurable improvement on persistent patterns of unequal treatment.14 Improving health outcomes for all children in Kentucky requires the thoughtful and intentional collection and analysis of data on race, ethnicity, place of residence, and language. This information can be used by both the Department for Medicaid Services and managed care organizations to identify disparities in care and to focus efforts on quality improvement. Another area to focus on is to offer the highest level of care to all children is design patient-centered and culturally-sensitive care. Some managed care organizations have found the following strategies helpful in improving services to children of color:

- Providing individualized outreach to engage and motivate members;
- Creating a feedback loop between patients and providers to improve adherence to medical regimens; and
- Encouraging culturally-competent contact between patients and doctors, through provider education, staff recruitment, staff training, translation services; and
- Developing accurate and appropriate health education materials for populations in the covered area.15

Managed care and children with special healthcare needs
In order to achieve cost savings while improving outcomes the state must give special attention to the impact on children, particularly those with special health care needs such as autism, asthma, obesity, diabetes, and epilepsy. Children with special health care needs could experience developmental delays due to illness and disability that can have short and long term effects on their health and future outcomes. The state must ensure that a managed care model will emphasize proactively preventing and treating chronic conditions. A child’s health and development also depends greatly on adult protection and guidance.16

When moving into a managed care system, the American Academy of Pediatrics recommends that:

- All involved in managed care, including pediatricians and families, fully understand how it works and how to advocate for services and system improvements;
- Policymakers have the necessary information and data to monitor managed care plans carefully for unintended, or negative effects on children, particularly children with special health care needs;
- Flexibility is provided to modify managed care plans if the programs turn out to be ineffective, reduce quality of care, or unnecessarily increase costs or barriers to care; and
- Families, doctors, and advocates must hold managed care organizations to standards of service and conduct that mirror their own obligations to children.17

Managed care and children in the child welfare system
Children enter the child welfare system after a report of suspected abuse or neglect, and these children tend to have an extremely high prevalence of physical and behavioral health problems.18 They require particular consideration under Medicaid managed care systems. State agencies are increasingly turning to managed care approaches to improve the delivery of physical and behavioral health services for children in the child welfare system.19 Collaborative relationships among managed care organizations, health care providers, mental health agencies, and child welfare agencies provide a unique opportunity to improve the children’s physical and behavioral health.20 The Child Welfare League of America and other experts suggest the following points to address barriers for children in the child welfare system:
• Use an appropriate capitated rate that is adjusted to better reflect the potentially high costs and elevated service needs of the child welfare population;

• Determine how to identify the high risk children in the child welfare system who are not in foster care. Identifying these children can ensure more timely and appropriate health care services and potentially avoid disruption in placement or the use of more expensive services;

• Leverage existing relationships by working collaboratively with state Medicaid and state or local child welfare agencies to improve outcomes for children;

• Ensure that data-sharing agreements are in place to protect the privacy of children and families so their medical information is handled carefully and only to provide the most appropriate care. This exchange of data between systems is essential for coordinating care; and

• Customize service delivery by providing access to primary care providers quickly, implementing effective referral and tracking systems, and ensuring that networks include the potential non-traditional providers that children in the child welfare system may need.

Managed care and school health services

A growing positive for Kentucky’s children is the trend toward providing health services in the school setting, which is generally a partnership between schools and local health departments. Yet in Kentucky’s only managed care arrangement, school health services are limited due to policies of the managed care provider. The Commonwealth cannot afford that kind of unintended consequence for any segment of the Medicaid population.

Like children in the child welfare system and children with special health care needs, school health services require special consideration when negotiating managed care plans. Schools may provide more complex and comprehensive health services than managed care organizations may realize or recognize. Advocates for school health services need to work together to promote the scope of school health services to any managed care provider that may serve children.

Some barriers exist which could make the partnership between managed care organizations and school health systems difficult. In some cases, school boards and other local authorities may prevent schools from offering important health services – part of this is due to the fact that little is known about the level of healthcare services provided by schools outside of staff and faculty. There is also a lack of data collection on services, utilizations, costs and outcomes of health care delivered in schools. This lack of data contributes to the perceptions that schools are unable to provide services required by managed care organizations.

While the managed care model has proven to be a mix of beneficial and negative outcomes across the country, the same is true for the 16-county region currently operating under managed care in Kentucky. School health services have been severely limited under the managed care system in the Passport service region. Passport receives funding from the Department of Medicaid Services based on the number of Medicaid recipients in the area. Passport then assigns each patient to a medical home with a specific health care provider. The patients are then required to receive primary care services through their assigned provider. Because school health services are not deemed “medical homes”, health departments in the Passport region cannot bill Medicaid for school health services. This has resulted in a decrease in school health services provided in the area. For example, the ratio of students per full-time equivalent nurse in the Passport region is 2,483 to 1. In Kentucky outside of Passport, the ratio is 787 students to 1 nurse. The national recommendation is 1 nurse for every 750 students in the general population. For students with more complex health care needs, like children in the child welfare system, the recommended rate can drop to 1 nurse for every 125 students.
School nurses have the education and expertise needed to promote timely, effective, and cost-efficient health services.\textsuperscript{31} School nurses are often the only individuals recognizing the health needs of children, particularly children with special needs, those in the welfare system, and economically disadvantaged children, and their presence in schools is crucial to ensuring the health and safety of Kentucky’s children.

**Forming strong partnerships among state agencies, managed care providers, health providers, consumers, and advocates is critical for success**

Kentucky’s Finance and Administration Cabinet sent out a request for proposals to managed care organizations in early April 2011. In mid-May, state officials will be reviewing proposals and anticipate a new model being put in place July 1. A successful Medicaid managed care program not only requires careful review and planning on the part of state officials, it also requires the support of plan members. This can be achieved through states forming sustainable partnerships with consumers and advocates that incorporates the following:\textsuperscript{32, 33}

1. **Communicating early and often:** The best way for states to avoid misinformation is to engage the consumer and advocacy communities as early in the process as possible. Providing meaningful opportunities for input will make the case for the benefits of managed care and build trust among stakeholders.

2. **Employing a multi-pronged engagement strategy:** States can use various ways to engage advocacy communities during program development, implementation, and oversight including public meetings, focus groups, and advisory and oversight committees.

3. **Supporting and valuing meaningful consumer participation:** States can provide information about the basics of managed care to consumer groups which can help to close the knowledge gap that may exist. Ideally, state officials would also meaningfully consider the input of stakeholders in the process. Kentucky already has infrastructure in place to learn about provider and consumer concerns. The MAC (Medicaid Advisory Committee) and the TACs (Technical Advisory Committees) act in an advisory capacity to Medicaid officials. It is critical that these committees remain viable and are able to hold the state and the selected managed care organization accountable.

4. **Determining ground rules:** States can work to reduce tensions by making sure all stakeholders are represented in committees, including advocates; facilitate meetings using a third party; promote meetings widely; and allow for questions and suggestions during meetings.

As the Commonwealth takes steps towards expanding Medicaid managed care in Kentucky and begins to review proposals, it has the potential to impact 430,000 children in Kentucky. This transition can bring both opportunities and challenges and it is crucial that the Commonwealth not only look to increase efficiencies within state government, but also look to improve health outcomes for all, particularly children. Managed care could naturally translate into improved access to needed care, but if plan or provider participation is inadequate, eligibility for Medicaid unstable, or the unique needs of the Medicaid population are overlooked, children could suffer most.

\begin{itemize}
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