

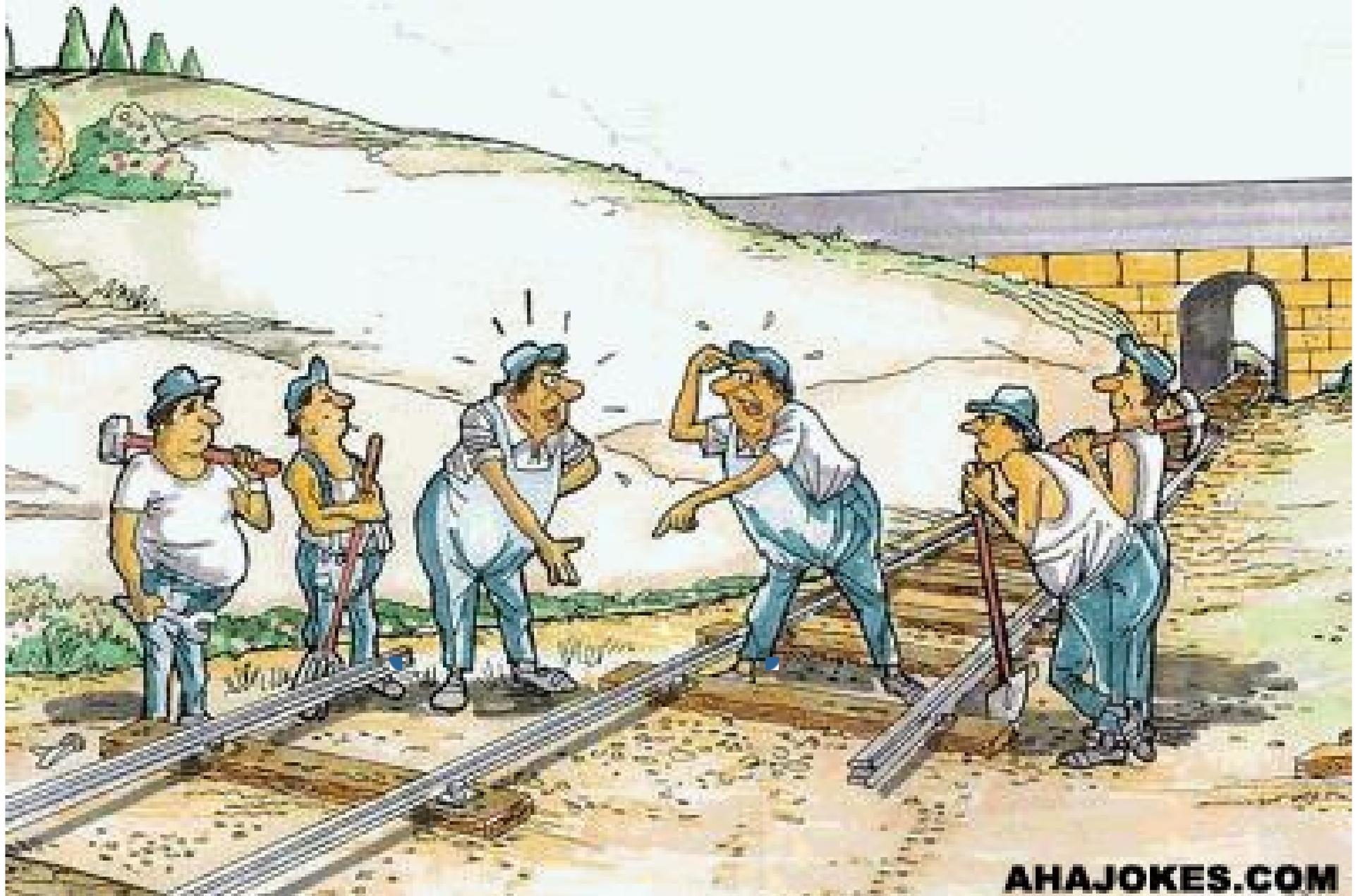


Kansas Health Policy Authority
Coordinating health & health care for a thriving Kansas

Data Consortium:

*Leveraging Kansas health data to advance
health reform via data-driven policy*

Team Work



Process/Performance Improvement (PI) Lifecycle

- Identification of area for improvement & issues (Health Policy)
- Benchmarking:
 - Peers
 - Self (historical)
- Survey of existing body of knowledge for best practices
- Planning:
 - Stakeholder identification & Team formation
 - Aim statement
 - Selection of interventions and timeline
 - Selection of PI metrics
- Implementation
- Data Monitoring:
 - Pre-(baseline) vs. post-implementation
 - Frequent and regular to track impact and fine-tune interventions

Outline

- Advancing Health Data Policy in Kansas:
 - » Role of the KHPA
 - » Statutory Charge
 - » Development of the Data Consortium
- National and State-level health consortia initiatives
- Examples of standardized public health metrics
- Summary of data available:
 - KHPA data:
 - » Program data – Medicaid, SEHBP
 - » KHIIS
 - » Data Analytic Interface
 - Data from other agencies/organizations – KDHE, KFMC
 - Data Sharing Issues

Outline (continued)

- Overview of Health Reform in Kansas
- Planned Reporting
- Core Task for the Data Consortium
- Consortium structure (workgroups) and governance
- Next Steps

Background / History:
Advancing Health Data Policy in
Kansas

Laying the Framework for Health Reform

- Phase I: 2005 and 2006: Formation of KHPA
 - Appointment of Board
 - Creation of vision principles and framework
- Phase II: 2007: Creation of Health for All Kansans Steering Committee
 - Passage of SB 11:
 - » Creates premium assistance program
 - » Outlines development of health reform options
 - Funding for KHPA data initiatives:
 - » Data Analytic Interface (DAI)
 - » Staffing
- Phase III: 2008: Promote Comprehensive Health Reform Options



Kansas Health Policy Authority

Coordinating health & health care for a thriving Kansas

- KHPA created in 2005 Legislative Session
- Built on Governor Sebelius' "Executive Reorganization Order"
- Modified by State Legislature to:
 - Create a nine member Board to govern health policy
 - Executive Director reports to Board
 - Added a specific focus on health promotion and data driven policy making

KHPA Board Members

- **Nine voting board members**

- Three members appointed by the Governor
- Six members appointed by legislative leaders.

- **Seven nonvoting, *ex officio* members include:**

- Secretaries of Health and Environment, Social and Rehabilitation Services, Administration, and Aging; the Director of Health in the Department of Health and Environment; the Commissioner of Insurance; and the Executive Director of the Authority.

KHPA Statutory Charge

- Develop and maintain a coordinated health policy agenda
- Effective purchasing of health care
- Employing health promotion oriented public health strategies
- Advancing data-driven decision-making

Source: *SB 272*

Programs Transferred to KHPA in 2006

- Medicaid
(Regular Medicaid)
- MediKan
- State Children's Health Insurance Program
- Ticket to Work/Working Healthy
- Medicaid Management Information System
- Medicaid Drug Utilization Review & related programs
- State Employee Health Insurance
- State Workers Compensation
- Health Care Data Governing Board
- Business Health Partnership Program

KHPA's Data Responsibilities

- ... develop or adopt health indicators
- ... may appoint a task force or task forces ... for the purpose of studying technical issues relating to the collection of health care data
- ... develop policy regarding the collection of health care data
- ... administer the health care database
- ... receive health care data ... as prescribed by the *authority*
- ... coordinate ... analysis of health data for the state of Kansas with respect to [its] health programs

STATUTORY VISION FOR HEALTH DATA

65-6801: urgent need to provide health care consumers, third-party payors, providers and health care planners with information regarding the trends in use and cost of health care services in this state for improved decision-making. This is to be accomplished by compiling a uniform set of data and establishing mechanisms through which the data will be disseminated.

- (b) It is the intent of the legislature to require that the information necessary for a review and comparison of utilization patterns, cost, quality and quantity of health care services be supplied to the health care database by all providers of health care services and third-party payors to the extent required by K.S.A. 65-6805
- (c) The information is to be compiled and made available in a form prescribed by the Kansas Health Policy Authority to improve the decision-making processes regarding access, identified needs, patterns of medical care, price and use of health care services.

Statutory Authority to Collect Data from:

- Medical Care Facilities
- Health Care Providers
- Providers of Health Care
- Health Care Professionals
- Home Health Agency
- Psychiatric Hospitals
- State Institutions for the Mentally Retarded
- Community Mental Health Centers
- Adult Care Homes
- Laboratories
- Pharmacies
- Board of Nursing
- Kansas Dental Board
- Board of Examiners in Optometry
- State Board of Pharmacy
- State Board Of Healing Arts and third party payors, including but not limited to licensed insurers, medical and hospital service corporations, health maintenance organizations, fiscal intermediaries for government funded programs, self funded employee health plans.

Formation of the Data Consortium

- Chartered by the Board in April 2006 to:
 - Guide KHPA in the management of programmatic and non-programmatic health data
 - Ensure continued public support and investment in the use of this data to advance health policy
 - Disseminate this wealth of data, in partnership with stakeholders
 - Ask and answer important health policy questions pertaining to:
 - » Affordability of health care
 - » Quality of health care
 - » Health status of Kansans

Data Consortium Membership

- Executive Director of the Health Policy Authority or designee (Chair)
- Department of Health and Environment
- Department of Social and Rehabilitation Services
- Kansas Insurance Department
- University of Kansas Medical Center
- University of Kansas Medical Center-Wichita
- Kansas Health Institute
- Kansas Foundation for Medical Care
- Kansas Medical Society
- Kansas Hospital Association

Data Consortium Membership

(continued)

- Kansas Association of Osteopathic Medicine
- Kansas Mental Health Association
- Kansas Association for the Medically Underserved
- Kansas Nurses Association
- AARP
- Kansas Public Health Association
- Kansas Health Care Association (KHCA)
- Kansas Association of Homes and Services for the Aging (KAHSA)
- Two self-insured employers appointed by Kansas Chamber of Commerce and Industry:
 - » Hills Pet Nutrition
 - » Lawrence Paper Co.

Data Consortium Charge

To serve as a multi-stakeholder public advisory group to the KHPA Board with the following specific responsibilities:

- Make recommendations regarding the scope of the Authority's responsibilities for managing health data;
- Recommend reporting standards and requirements for non-programmatic data owned or managed by the Authority;
- Craft data use policy recommendations governing access to health information by external users;
- Recommend empirical studies and evaluations supporting the goals and objectives of the Authority;
- Provide input on health and health care data initiatives in other organizations and agencies;
- Develop recommendations for public reporting standards for consumers, health care providers and other health care organizations.

National and State-Level Data Consortia Initiatives

Massachusetts Health Data Consortium

- Founded in 1978 by state's major public & private health care organizations to act as a neutral agency to collect, analyze, and disseminate health care info
- Organized as a non-profit, pvt 501(c)(3) membership organization
 - Governed by board of managers
 - Funded by membership fees and grants
- Produces reports related to:
 - » Population health status & socioeconomic characteristics
 - » Marketing & planning of health svcs
 - » Community needs, health facilities, svcs, and manpower
 - » Pvt and public sector health insurance plans
 - » Other services: HIPAA transaction exchange, record locator svc, clinical data exchange

Maine Health Data Organization

- Formed in 1996 as an independent executive agency to:
 - » Collect clinical and financial health care information
 - » Exercise responsible stewardship in making this info accessible to the public
 - » Create and maintain a useful, objective, reliable, & comprehensive health info database that is publicly accessible while insuring patient confidentiality
 - » Improve the health of Maine citizens and issue reports
- Governed by 20-member Board:
 - 18 appointed by governor:
 - » 4 represent consumers, 3 employers, 2 payors (3rd party), 9 providers
 - 2 appointed by commissioner
- Developing a Claims Data Bank for privately insured, Medicaid, and Medicare that will allow analysis of health cost drivers, utilization, and quality of care

Texas Health Care Information Council

- Created by Texas legislature in 1995 to establish a statewide health care data collection system to enable informed decision making about providers
- Mandated to collect information on health care charges, utilization, provider quality, and outcomes to facilitate the promotion and accessibility of high quality, cost effective health care
- Governed by 19-member board:
 - » 15 stakeholders in the health care delivery system of Texas, including hospitals, physicians, health plans, consumers, business, labor, and health experts
 - » Directors or designees of four state agencies involved in health or insurance
 - » Operates under Texas Health and Human Services
- Public reporting on: Hospitals (inpatients), outpatient facilities, and HMOs

Public Health Data Standards Consortium

- Voluntary confederation of federal, state and local health agencies; national and local professional associations; and public and private sector organizations
- Goal: To develop, promote, and implement data standards for population health practice and research
- Formed 1999, became non-profit in 2003
- Members: Fed: AHRQ, CDC, NLM, SAMHSA; State: CA, MA, NE, OH, WI, GA, MN

Kansas Data Consortium

- In Kansas, a state agency is charged with overall responsibility for data policy
- The Data Consortium advises the state agency
- Only ME and MA have access to similar range of data

Examples of Standardized Public Health Metrics

National Standards

- Quality Alliance Steering Committee (QASC):
 - AHRQ/CMS/RWJF Initiative beginning 2006
 - Collaborative effort between quality alliances, government, physicians, nurses, hospitals, health insurers, consumers, accrediting agencies and foundations
 - Developing standards to promote public reporting for:
 - » Improvement directly by providers;
 - » Consumer decision-making; and
 - » Effective policies, payment policies and consumer incentives that reward or foster better provider performance.
 - 144 NQF-approved measures adopted in 22 areas of medical practice

National Standards

- Health care Effectiveness Data and Information Set (HEDIS): Used by 90% of America's health plans
- Consumer Assessment of Health care Providers and Systems (CAHPS): Public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care
- Joint Commission on Accreditation of Health care Organizations (JCAHO) Core Measures
- Agency for Health care Research and Quality (AHRQ)
- National Quality Forum (NQF)
- Health Disparities Collaborative (HDC) Measures

Example Measures

- Insurance/Health Plans:
 - Quality: Eye exams for people with diabetes; Breast cancer screening; Prenatal care
 - Financial/Economic: Variations in premiums, deductibles, co-pays over time; Market penetration by demographics
 - Access: Adults' access to ambulatory health services

Example Measures

- Providers (Hospitals/Physicians):
 - Quality: Complication rate; Time to recovery; ER visits
 - Financial/Economic: Reimbursement rates; Charges
 - Access: Demographics of patients served by facility/physician

Data Currently Managed by KHPA

Current Realities

- Huge stock of health care and provider data:
 - Medicaid/SCHIP
 - State Employee Health Benefits/Workers' Compensation (SEHBP)
 - Kansas Health Insurance Information System (KHIIS)
 - Licensure
 - Hospital Inpatient Claims
- Objective: Data-driven health policy
- Need to advance role of data in policy and the marketplace

Medicaid/SCHIP

- Medicaid Management Information System (MMIS) and Decision Support System (DSS)
- Medicaid/Healthwave claims, payments, encounters, enrollment, and quality
- Used for:
 - » Utilization and Expenditure (MAR – Medical Assistance Report)
 - » Caseload projections
 - » Institutional reimbursement
 - » Program management and procurement
 - » Managed care enrollment
 - » Ad hoc reports

SEHBP

- Claims and enrollment data from multiple private companies who provide health insurance coverage to State of Kansas employees, affiliated non-State entities and the State Worker's Compensation System
- Used for :
 - » Monitoring utilization and expenditures
 - » Benchmarking with Medicaid
 - » Routine reports to Health care Commission
 - » Program redesign and procurement

KHIIS

- Data from the major health insurance carriers in Kansas (Commercial group insurance plans)
- Health benefit, enrollment and claims data
- Collected and managed on behalf of the Commissioner of Insurance
- Data is to support assessment of insurance benefits and their relationship to costs

Other databases

- Licensure (Health care professional) database – Data from 8 licensure boards
- Hospital Inpatient Claims database – Collect discharge data from community and specialty hospitals

Current Needs

- Need the ability to respond to questions from diverse stakeholders
- Access to data by staff with different levels of need and skill
- Modern analytical tools

→ *DATA ANALYTIC INTERFACE (DAI)*

DAI – Desired Functionality

- Allow benchmarking of Kansas Medicaid/non-Medicaid/external normative data
- Rapid response to wide range of questions from diverse stake-holders
- Value-added tools:
 - » Episode groupers
 - » Record linkage to create master patient/provider index
 - » Built-in calculation of widely-accepted measures for acute/long-term health care quality
- Allow monitoring of policy impact by tracking input, process, and outcome measures factored by population, age, gender, location, etc.
- Support data-sharing (with suitable privacy controls) with other state agencies and external researchers

RFP Preparation

- Survey of states
- Trips
 - Iowa
 - » Built own Medicaid system
 - Nebraska
 - » Purchased system
 - Vendor Conference
- Reviewed a number of states RFP's
- Had potential vendors visit Kansas: Medstat, Ingenix, EDS, Bull Services

RFP Requirements

Repository for three data sets:

- Medicaid
 - 300,000
- State Employee Health
 - 88,000
- Private Insurance
 - 700,000+

RFP Requirements (cont'd)

- Web based
 - Easily accessed by staff
 - Quick response time
 - User friendly
 - Accurate reporting with ability to change and save queries

- Meet needs of
 - Administrators
 - Program staff
 - Analytical staff

- Training at six levels of staff

DAI Timeline

- DAI High Level Plan Approval – October 12, 2006
- RFI – May 11, 2007
- RFP – July 25, 2007
- Bids closed October 25, 2007
- Anticipated start date is March, 2008
- Proposed development time is one year





KDHE – Data Sources

Vital Statistics

- Births (Natality), Deaths (Mortality) , Stillbirths, Marriages, Divorce and Abortions—data are gathered from Kansas’ Civil Registration System
- Population-based—all events required reporting by State law
- Includes a significant amount of demographic and medical information
- Not a good source for information on morbidity (why we get sick) or risk behaviors.
- KDHE maintains public health data files and can provide information for at least the past 20 years. Earlier years present issues with standardization, compatibility
- Considered the “Gold Standard” for certain data such as prenatal care estimates, risk factors affecting birth outcome and cause of death Data are widely disseminated in aggregate form. Limited dissemination at record-level. Used extensively for health evaluations at federal, state and local level.



KDHE – Data Sources

Kansas Behavioral Risk Factor Surveillance System (BRFSS)

- BRFSS is an annual population–based telephone survey system collecting health information on non-institutionalized adults 18 years and older.
- Office of Health Promotion, KDHE conducts this survey annually, thus providing an ability to examine and monitor the trends of various diseases and risk factors/ behaviors of public health importance.
- The data is used in developing public health programs, policy making and establishing state and local priorities to address health related issues.



KDHE – Data Sources

Hospital Discharge data

- Dataset acquired annually from the Kansas Hospital Association for public health assessment.
 - Data maintained only on Kansas residents who have inpatient stays in any hospital (excluding specialty hospitals).
- Contains rich information about conditions treated in hospital by specific ICD codes
- Limited only to inpatient—problematic when more procedures are being performed in outpatient settings.



KDHE – Data Sources

Kansas Cancer Registry (K.S.A. 65-102)

- Population-based source of cancer incidence, includes 350,000 records since 1968
- Provides information on occurrence, stage of diagnosis and cancer survival.
- Physicians, labs, hospitals are required to report.
- Used by researchers, medical professionals, public health professionals for planning, evaluation and monitoring efforts
- Confidentiality includes personal identifiers protected by K.S.A. 65-102B and may not be disclosed except as provided by statute



KDHE – Data Sources

Other Datasets that may be of interest:

- Immunization Registry
- Maternal-Child Health
- Trauma Registry
- Children with Special Health Care Needs
- Disease Surveillance System
- Lead Screening
- Newborn Screening
- WIC
- Youth and Adult tobacco survey



KFMC Data Sources

■ Abstracted data

- Nursing Home Minimum Data Set (MDS)
- Hospital topic specific (adult only)
- Home Health Outcome and Assessment Information Set (OASIS)
- Childhood Immunization Data (Medicaid HCK, and HealthWave populations)

■ Survey data

- Consumer satisfaction surveys (HCK CAHPS, Medicare & HW MCO CAHPS, Hospital CAHPS, Nursing Home)
- Provider satisfaction surveys (HCK, HW, Nursing Home)
- Medicaid Access Monitoring (appointment and after-hours availability, geographical access)

KFMC Data Sources – cont'd

■ Administrative

- Medicare FFS claims, enrollment/eligibility
- Medicaid claims, enrollment/eligibility
- HealthWave encounters, enrollment/eligibility
- Medicare and Medicaid/HW provider files

■ Reports

- Hospital 30 day risk adjusted mortality (AMI, heart failure, pneumonia)
- HealthWave MCO HEDIS
- Medicare Advantage Health Outcomes Survey report
- Medicare Hospital Utilization Trending reports
- National CAHPS Benchmarking Database

Validation

- **Measure Validation:** Validity and reliability of the measure. Does it accurately measure what is intended?
 - Validated measure resources: NQF, NCQA, AHRQ
 - Validation of created measures through approved protocols
- **Data Validation:** level of consistency and accuracy of the data submitted by hospitals, MCOs, physicians
 - Administrative data (claims/encounters/other databases)
 - Abstracted data (adherence to measure specifications for data collection)

Data Sharing: Issues and Challenges

- Inventory of all data tracked and reports generated by Kansas organizations and agencies
- HIPAA
- SSA
- Data-sharing agreements

Overview of Health Reform in Kansas

Goal of Health Reform in Kansas

To improve the *health* of Kansans – not just health insurance or health care – but the *health* of our children, our families, and our communities

Kansas Health Reform Overview

- 2005 and 2006: Creation of KHPA
 - Appointment of Board
 - Creation of vision principles and framework
- 2007: Creation of Health for All Kansans Steering Committee
 - Passage of SB 11:
 - Created premium assistance program
 - Outlined development of health reform options
- 2008: Debate Health Reform Options
 - Legislative debate

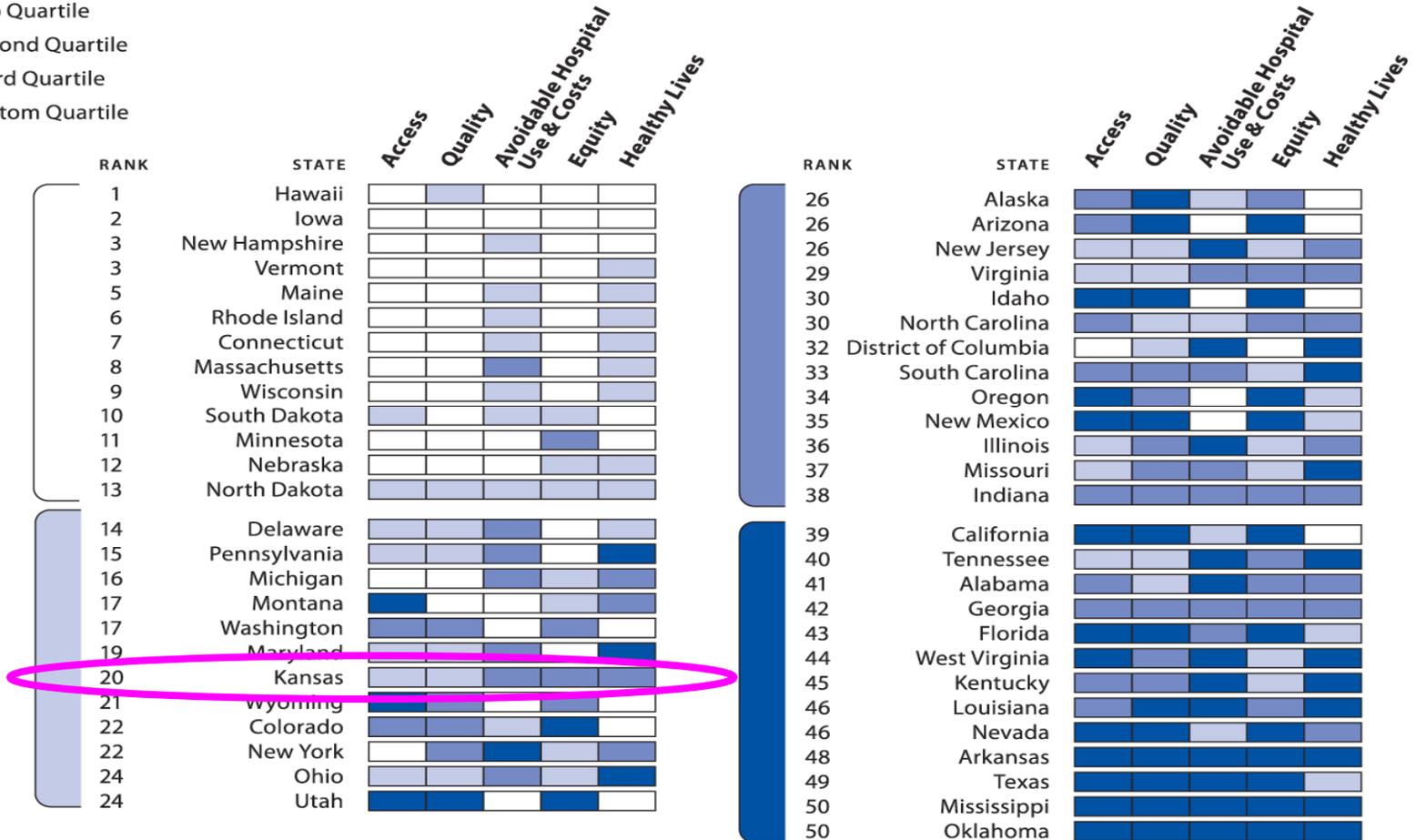
Identifying the Issues

Problems in the health and health care
system in Kansas

Health in Kansas: Room for Improvement

State Scorecard Summary of Health System Performance Across Dimensions

State Rank
 □ Top Quartile
 □ Second Quartile
 □ Third Quartile
 ■ Bottom Quartile

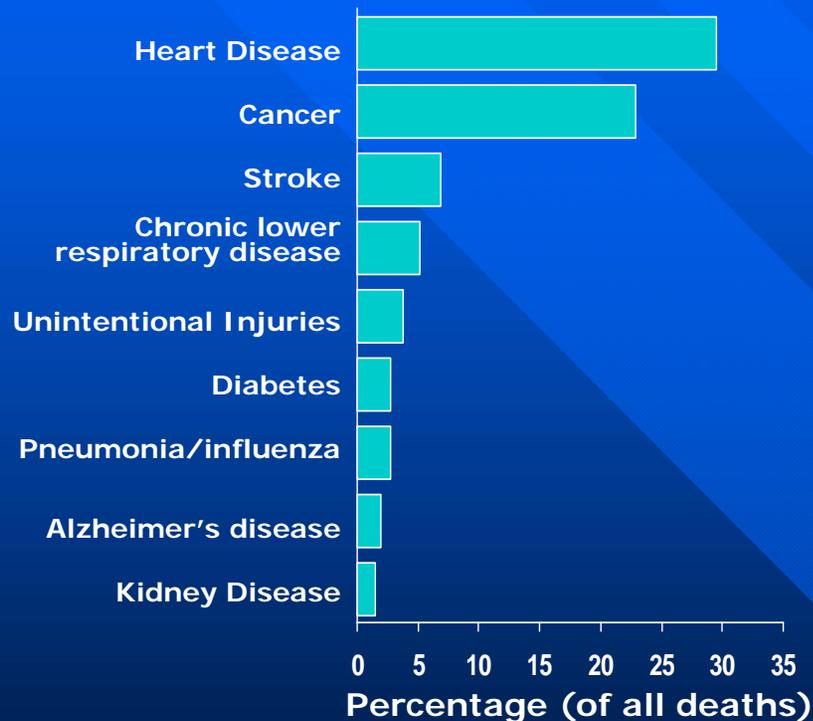


SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

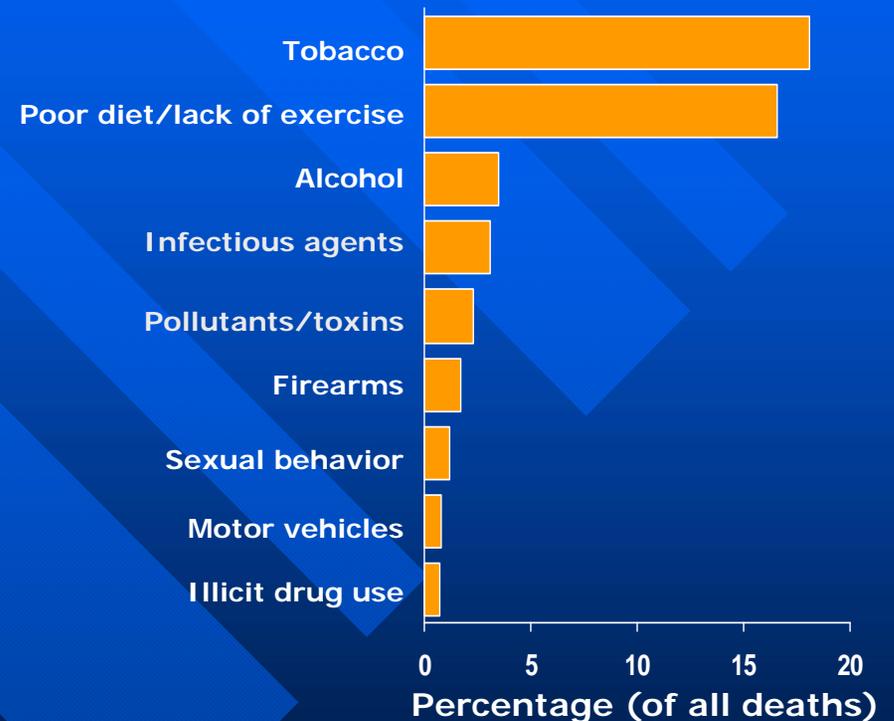
What is making us sick?

Causes of Death United States, 2000

Leading Causes of Death*



Actual Causes of Death†

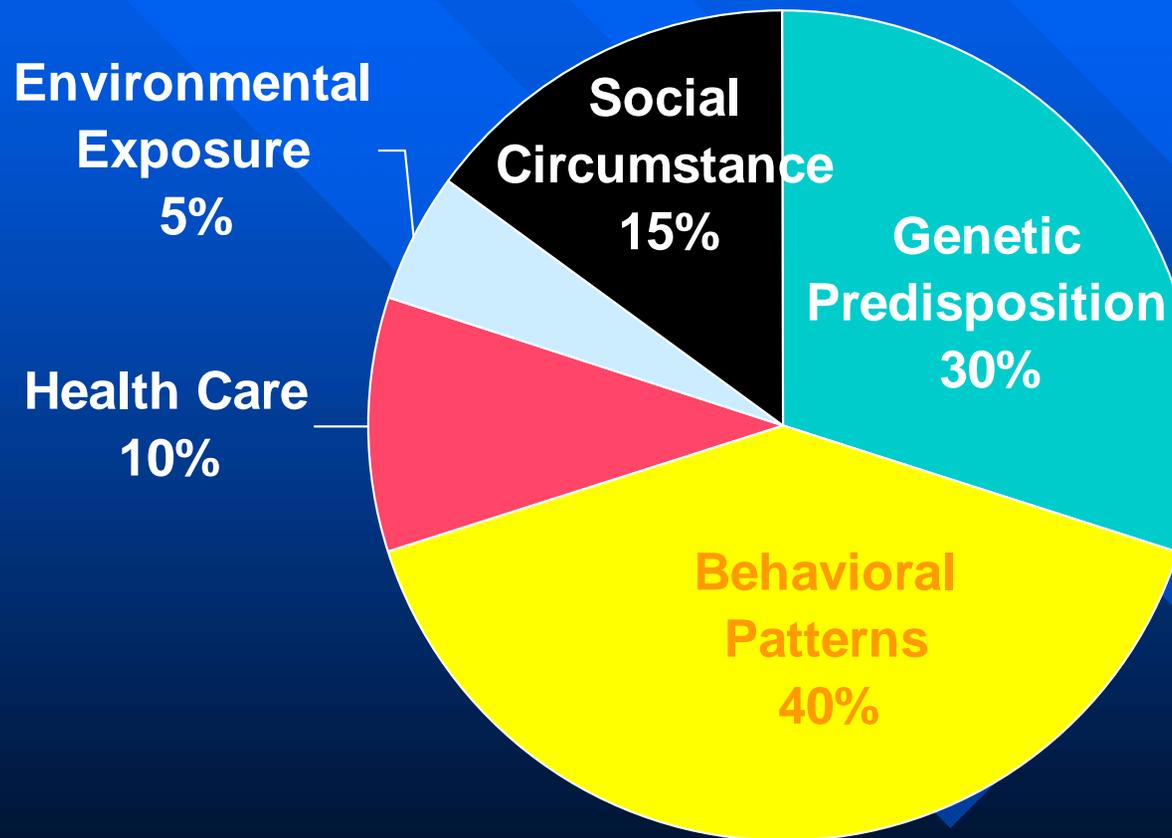


* National Center for Health Statistics. Mortality Report. Hyattsville, MD: US Department of Health and Human Services; 2002

† Adapted from McGinnis Foege, updated by Mokdad et. al.

Determinants of Health Status

Proportional Contribution to Premature Death



Source: Schroeder SA. N Engl J Med 2007;357:1221-1228

Why All Three Priorities Matter

■ Rise in Health Care Costs

- 75% of spending associated with chronically ill (CDC, Chronic Disease Overview, 2005)
- Nearly 2/3 of rise in spending associated with increases in chronic diseases (Thorpe, The Rise in Health Care Spending and What to Do About It, *Health Affairs* 2005; 24(6):1436-1445)
- Nearly 30% of cost increase associated with rising obesity rates, which nearly doubled over past 20 years (Thorpe, The Impact of Obesity on Rising Medical Spending, *Health Affairs* 2004; 23:w480-w486)

■ Preventive Care

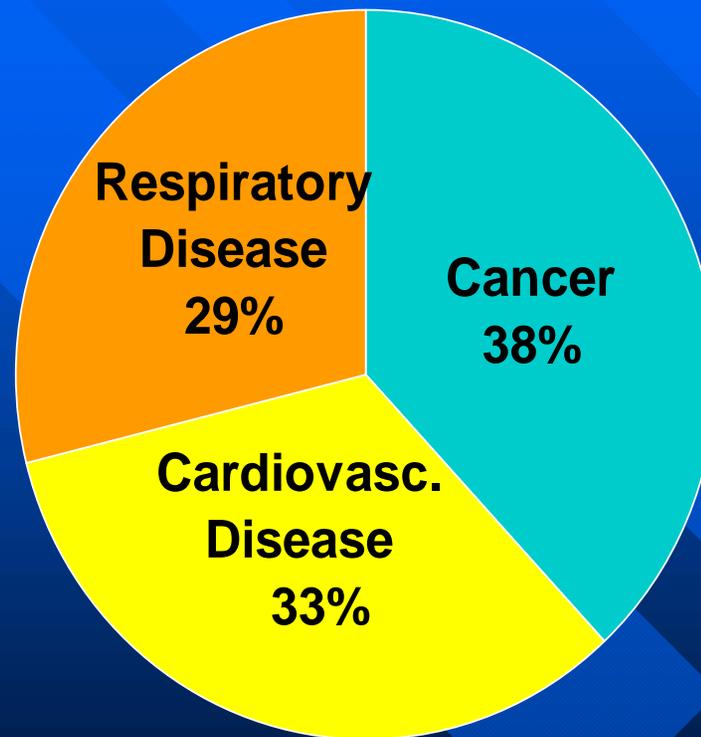
- Chronically ill only receive 56% of clinically recommended preventive care (McGlynn et al., The Quality of Health Care Delivered to Adults in the U.S., *NEJM* 2003; 348(26): 2635-2645)

Tobacco Use in Kansas

- Kansas Adults
 - 20% are current smokers
- KS High School Students
 - 21% are current smokers
 - 15% currently use smokeless tobacco
- KS Middle School Students
 - 6% are current smokers

Tobacco Related Deaths in Kansas

Average of 3,900 Deaths per Year
in Kansas Due to Smoking



Source: Smoking Attributable Morbidity, Mortality and Economic Cost, CDC

Cancer Rates in Kansas

■ Breast and Cervical Cancer

- Nearly 400 women die annually
- Access to timely screening could prevent 60-120 of those deaths

■ Prostate Cancer

- Most common cancer among men
- Over 1,800 cases annually diagnosed
- 250 men die each year

■ Colorectal Cancer

- Average of 550 persons die each year
- CDC indicates that routine screening can reduce deaths by 60%

Cost of Tobacco in Kansas

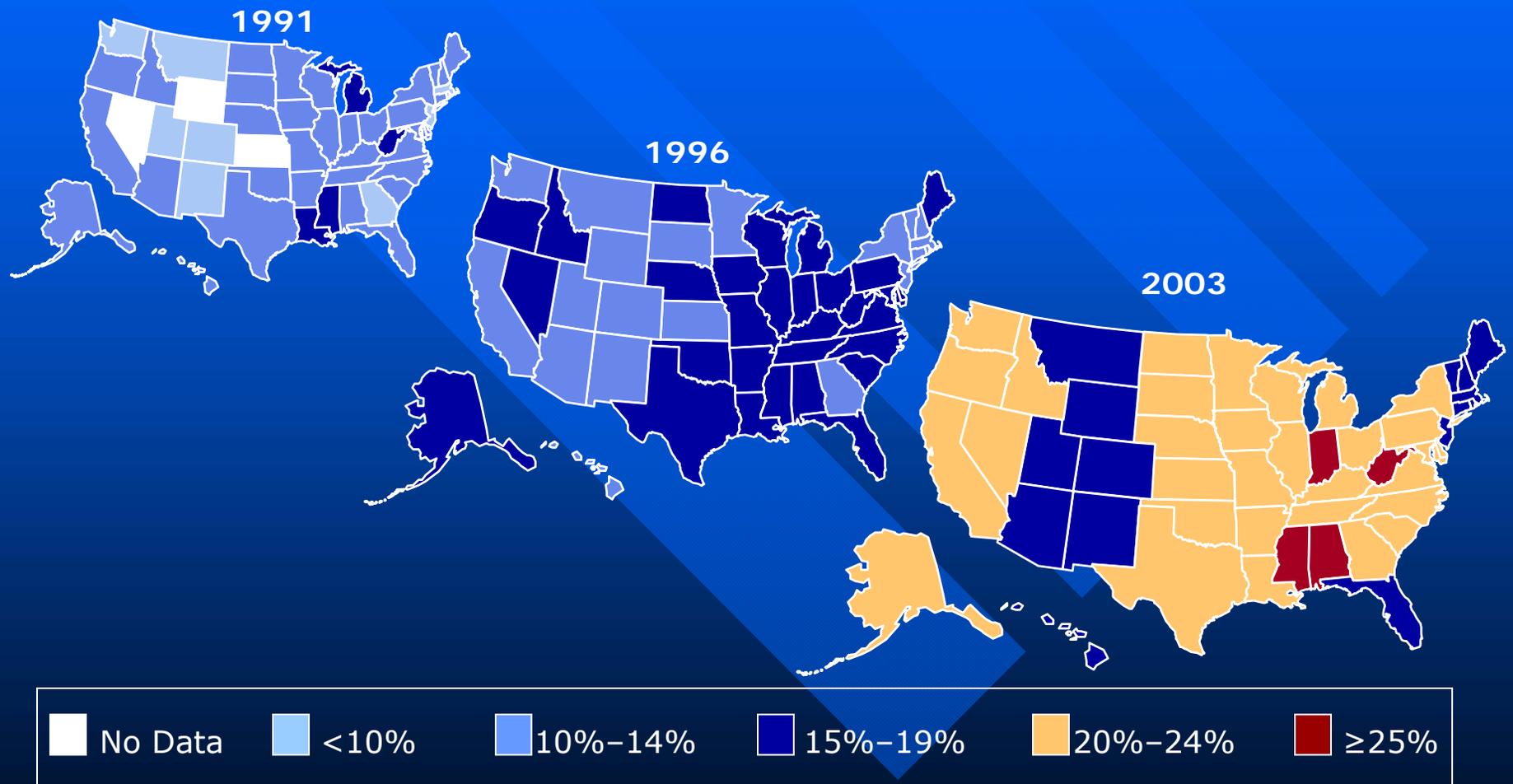
- Causes 4,000 deaths annually in Kansas
- Costs \$930 million in health care costs yearly; \$196 million in Medicaid program alone
- Increase of 10% for pack of cigarettes will decrease tobacco use by 4%
- Majority (64%) of Kansas adults support an increase in tobacco user fee (Sunflower Foundation Poll, 2007)

Impact of Secondhand Smoke

- *Smoking is the #1 preventable cause of death in Kansas*
- In US, 126 million nonsmokers are exposed to secondhand smoke
- **US children most at risk**; 60% of ages 3-11 are exposed to secondhand smoke
- In KS, 28% of workers are NOT protected by worksite nonsmoking policies

Obesity Trends* Among U.S. Adults BRFSS, 1991, 1996, 2003

(*BMI ≥ 30 , or about 30 lbs overweight for 5'4" person)



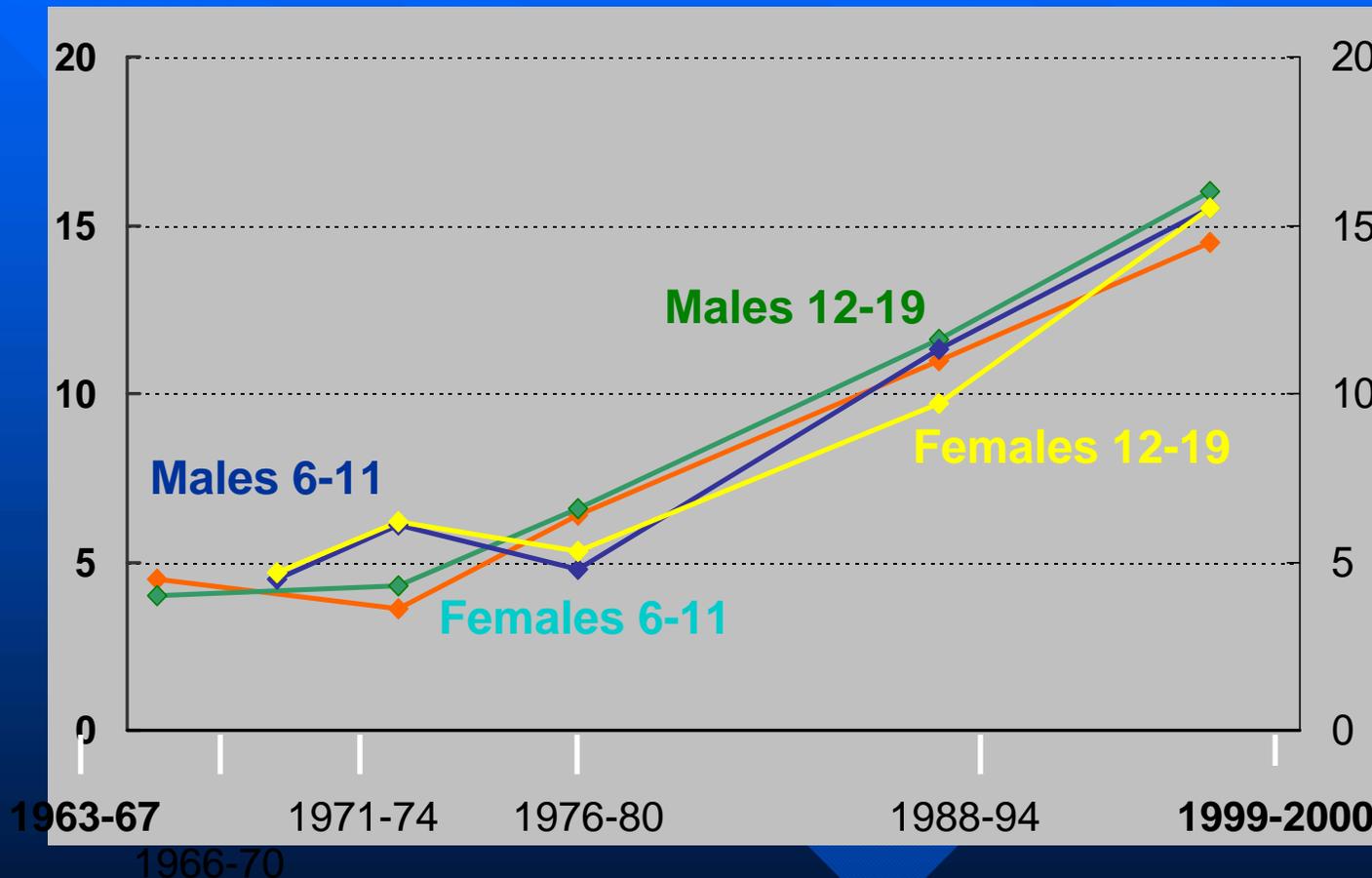
Obesity and Nutrition in Kansas

- **2/3 of Adults were Overweight or Obese In Kansas (2006)**
 - 36% of adults were overweight
 - 26% of adults were obese
- **Nutrition in Kansas**
 - 23% of adults consumed less than 5 servings of fruits and vegetables in 2000
 - Decreased to less than 20% in 2005

U.S. Trends for Overweight Children and Adolescents

Percent

Percent



Note: Overweight is defined as BMI \geq gender- and weight-specific 95th percentile from the 2000 CDC Growth Charts for the United States. Source: National Health Examination Surveys II (ages 6-11) and III (ages 12-17), National Health and Nutrition Examination Surveys I, II, III and 1999-2000, NCHS, CDC.

Overweight Students in Kansas

- Nearly 1/3 of Kansas students are either overweight or at-risk for being overweight.
- Percent of **overweight students**, 2004-2005:

17%	15%	12%
Elementary	Middle	High

- Percent **at-risk for becoming overweight**, 2004-2005:

15%	17%	13%
Elementary	Middle	High

Source: 2004-2005 Kansas Child Health Assessment and Monitoring Project (K-CHAMP). Kansas Dept of Health and Environment; Office of Health Promotion. Accessed on October 9, 2007 at <http://www.kdheks.gov/bhp/kchamp/data.html>.

Physical Education & Activity in Kansas Schools

- Students NOT meeting recommended levels of physical activity:
 - Elementary School: 39%
 - Middle & High School: 43%
- Students NOT enrolled in daily PE classes:
 - Elementary School: 77%
 - Middle & High School: 54%
- Students NOT exercising or playing sports for 20 minutes during PE class:
 - Elementary: 27%
 - Middle & High School: 11%

Kansas Schools & Nutrition

■ Foods Available in Schools¹

- Almost 45% of K-12 schools offer a la carte lunch items.
- Just under 60% of K-12 schools and 90% of high schools have vending machines.

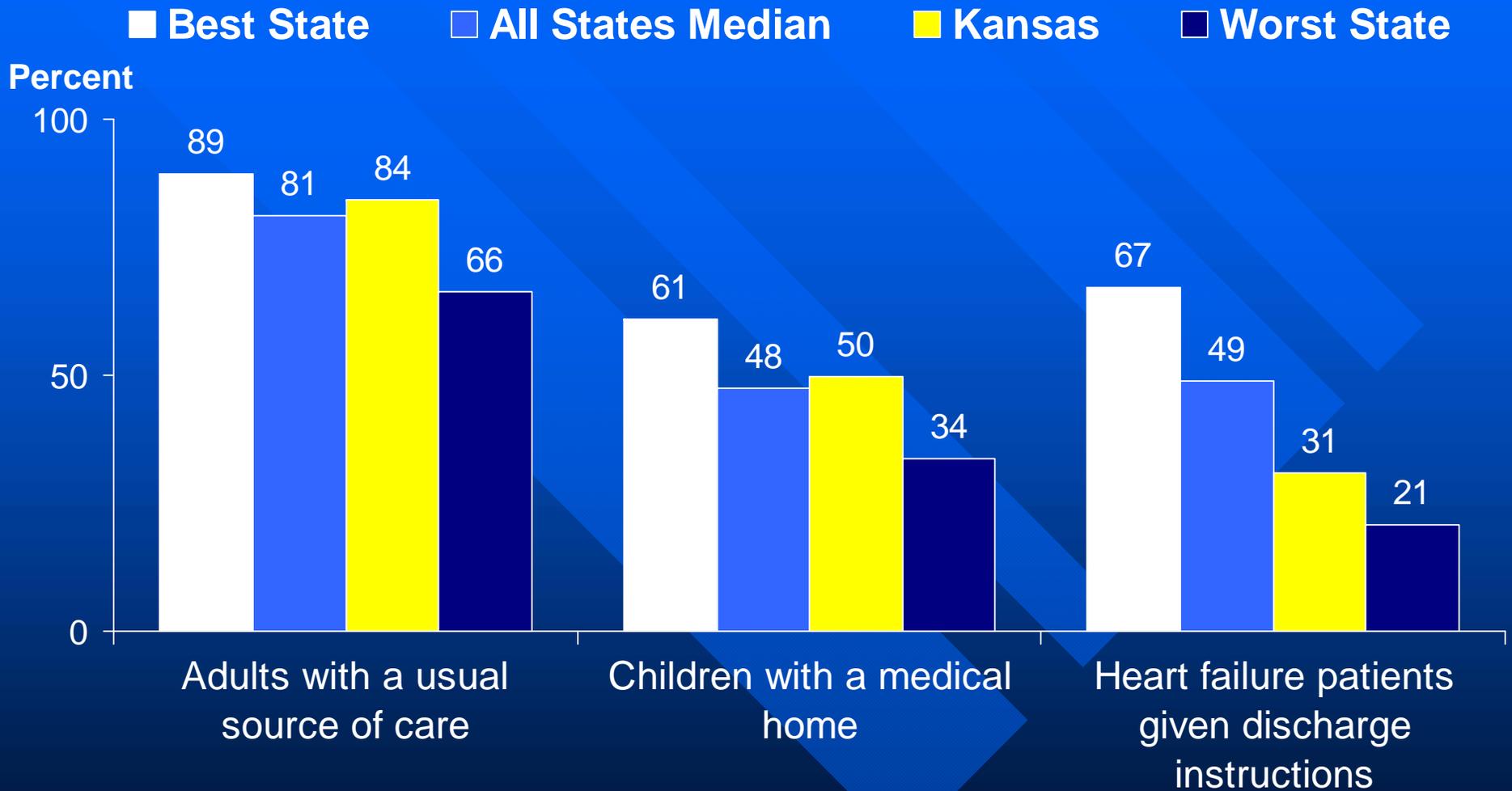
■ Nutrition of Students²

- Percent of students who eat the recommended five fruits & vegetables each day –
 - » Elementary School: 19%
 - » Middle School: 22%
 - » High School: 18%

What is wrong with our health
care system?

QUALITY: COORDINATED CARE

State Variation: Coordination of Care Indicators



DATA: Adult usual source of care – 2002/2004 BRFSS; Child medical home – 2003 National Survey of Children’s Health; Heart failure discharge instructions – 2004-2005 CMS Hospital Compare SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

EQUITY

Lack of Recommended Preventive Care by Income and Insurance

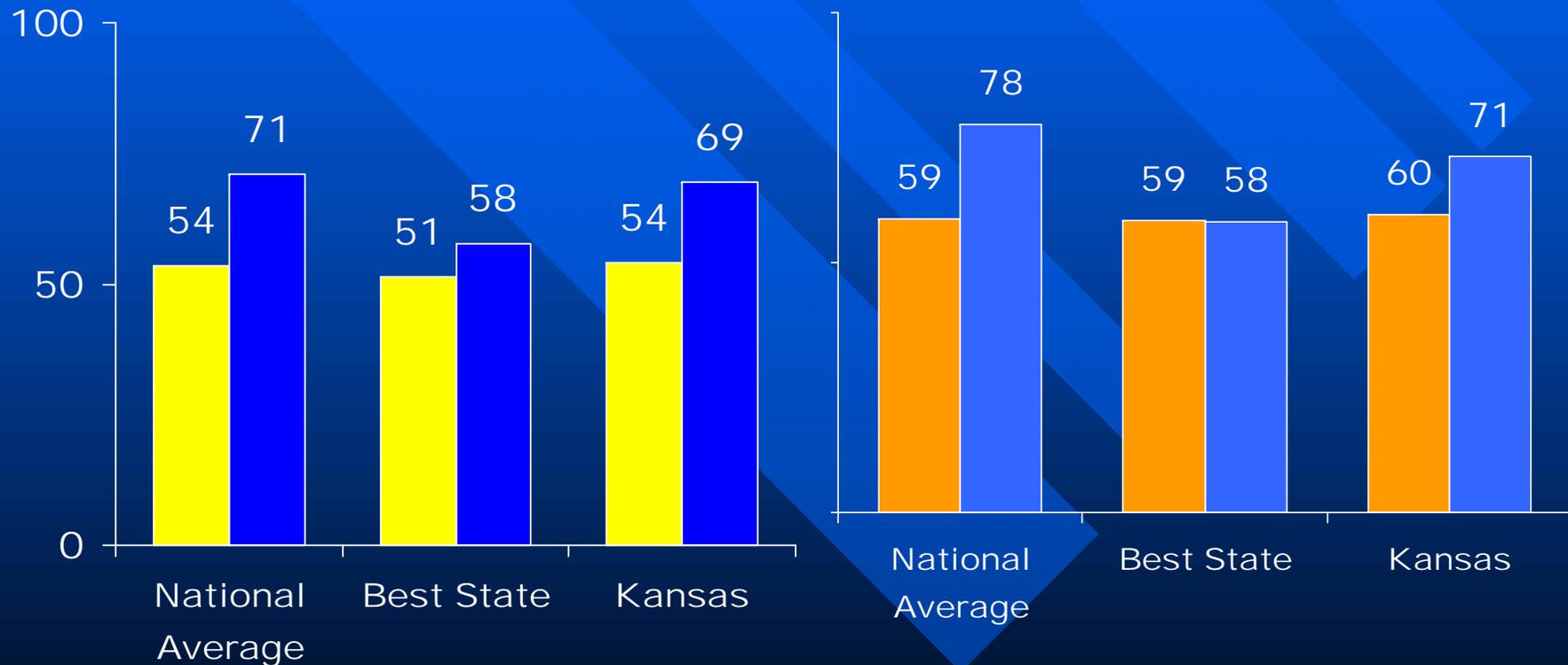
Percent of adults age 50+ who did NOT receive recommended preventive care

By income

By insurance

■ >200% of poverty ■ 200% of poverty or less

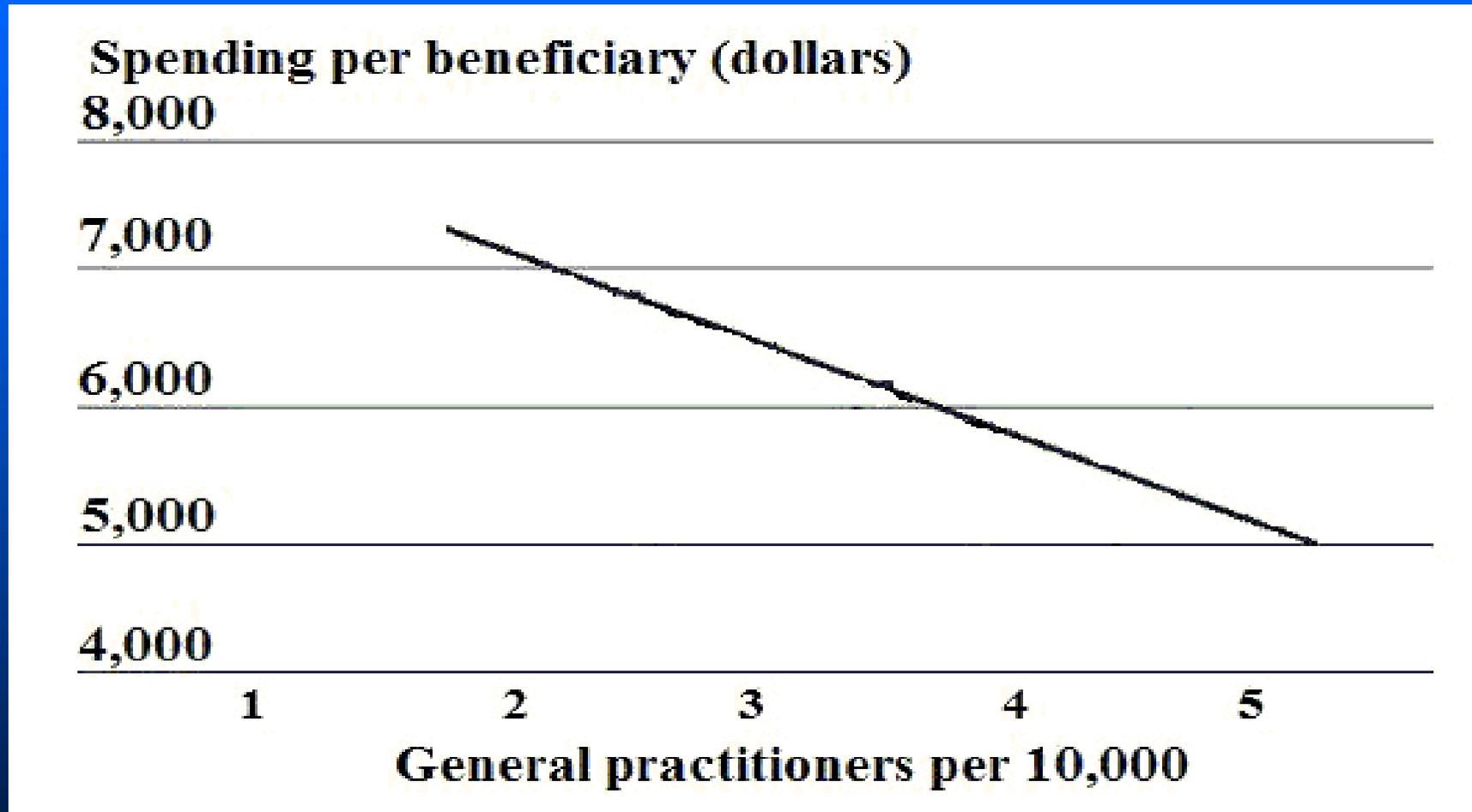
■ Insured ■ Uninsured



Note: Best state refers to state with smallest gap between national average and low income/uninsured.

DATA: 2002/2004 BRFSS. SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

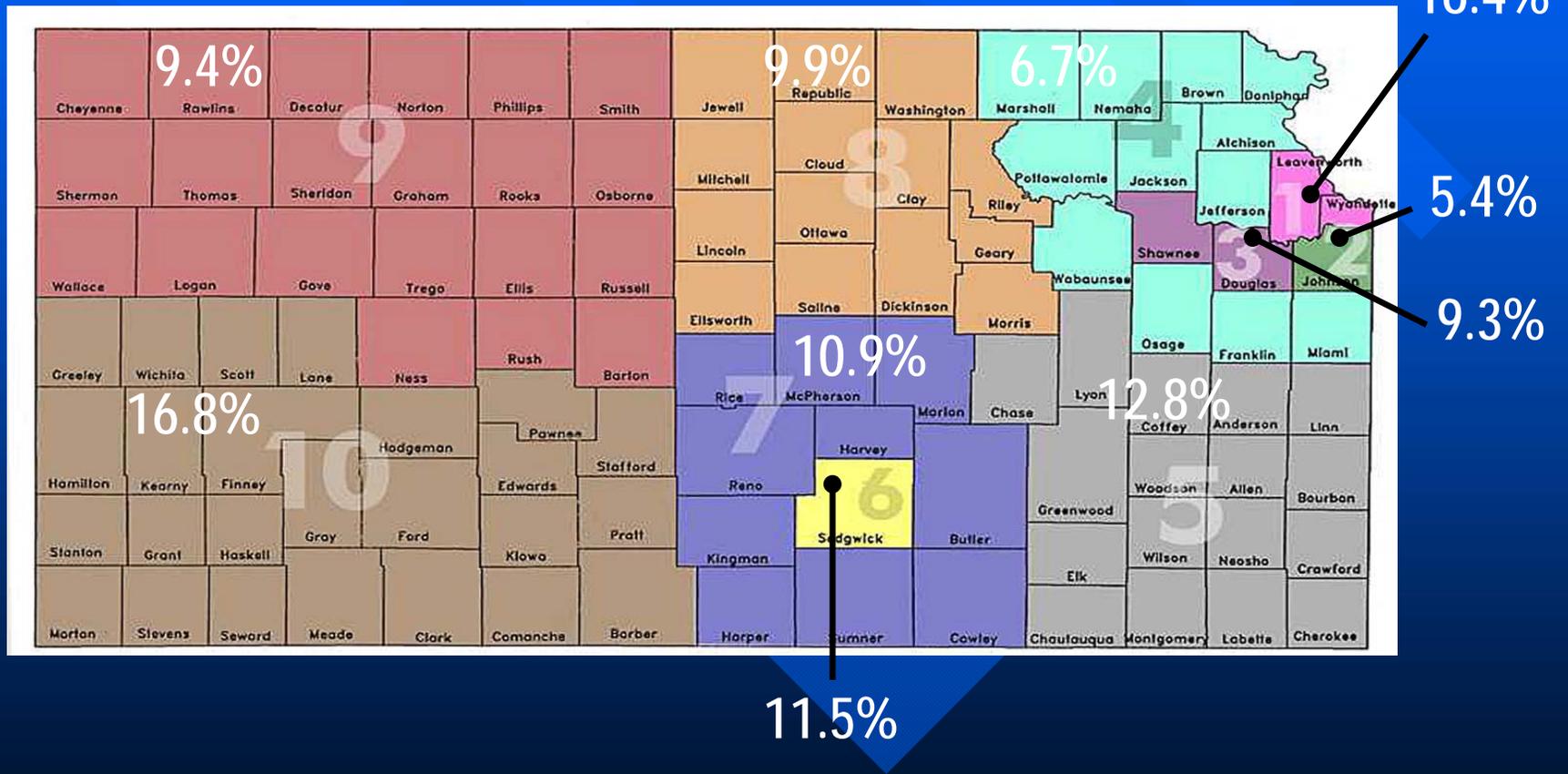
Primary Care as it Relates to Cost



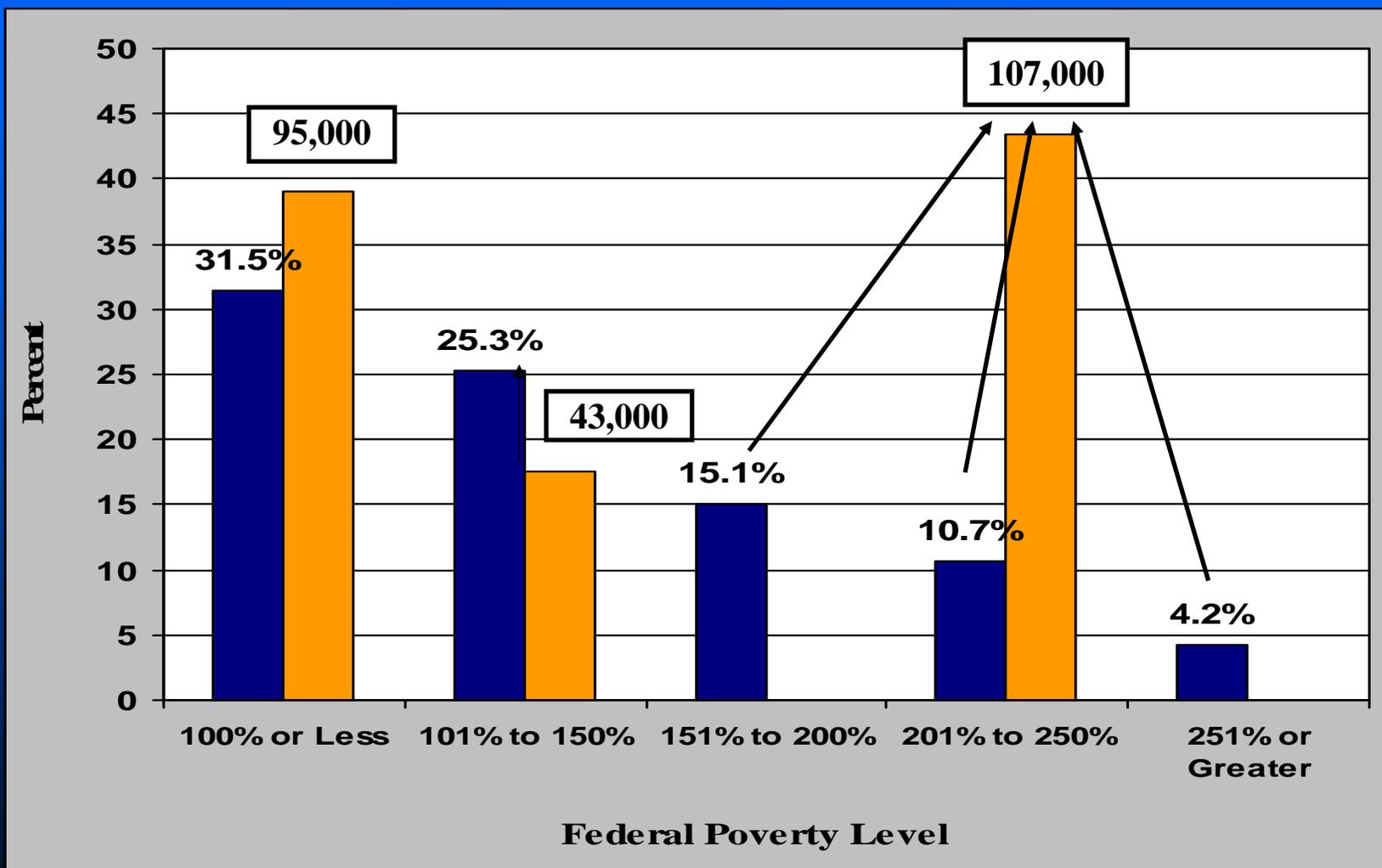
Source: Baicker K, Chandra A. Health Aff (Millwood) 2004;Suppl Web:W4-184-97₇₆

Uninsured Kansans Under Age 65, by Region

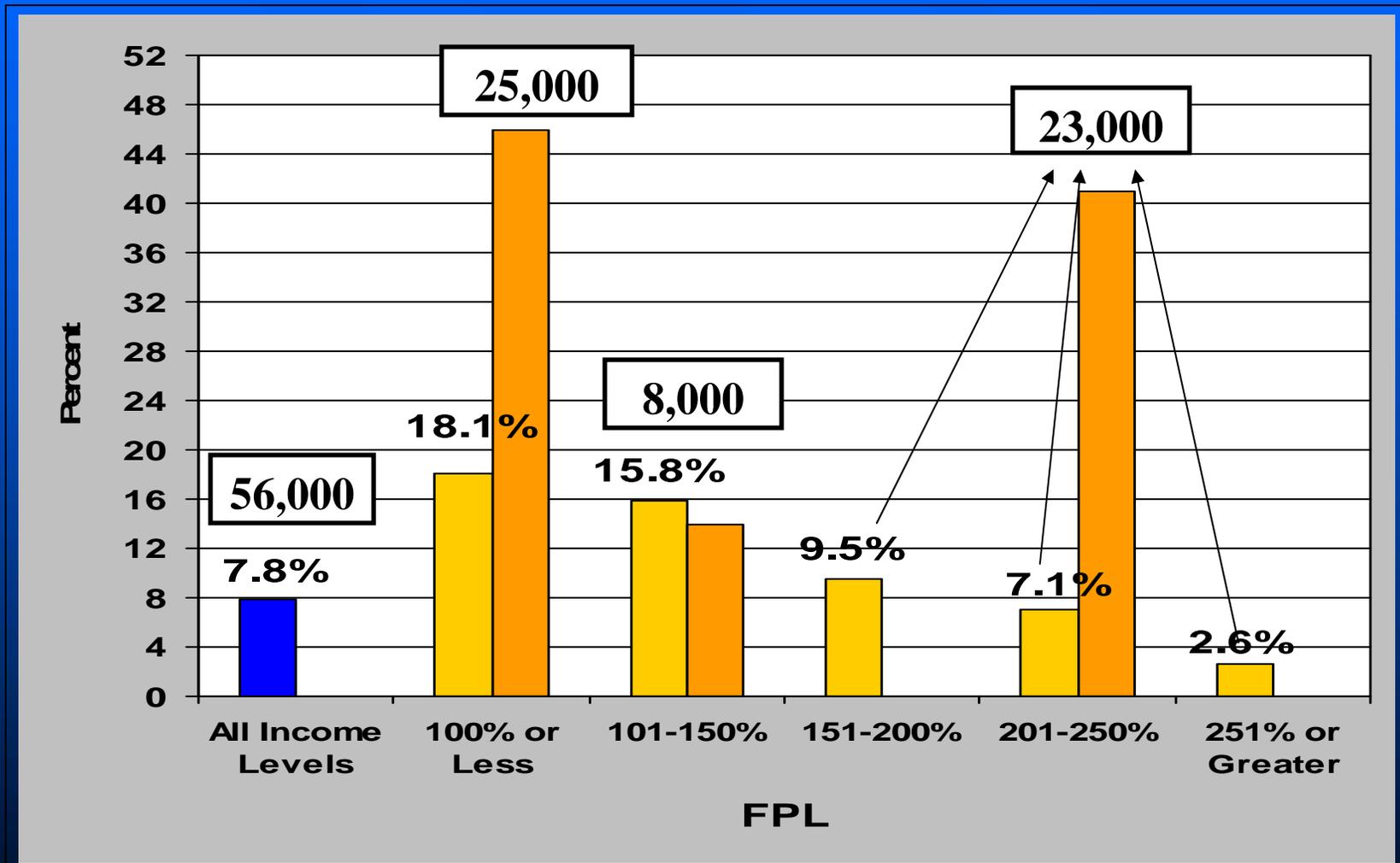
Total Uninsured in Kansas: 10.5%



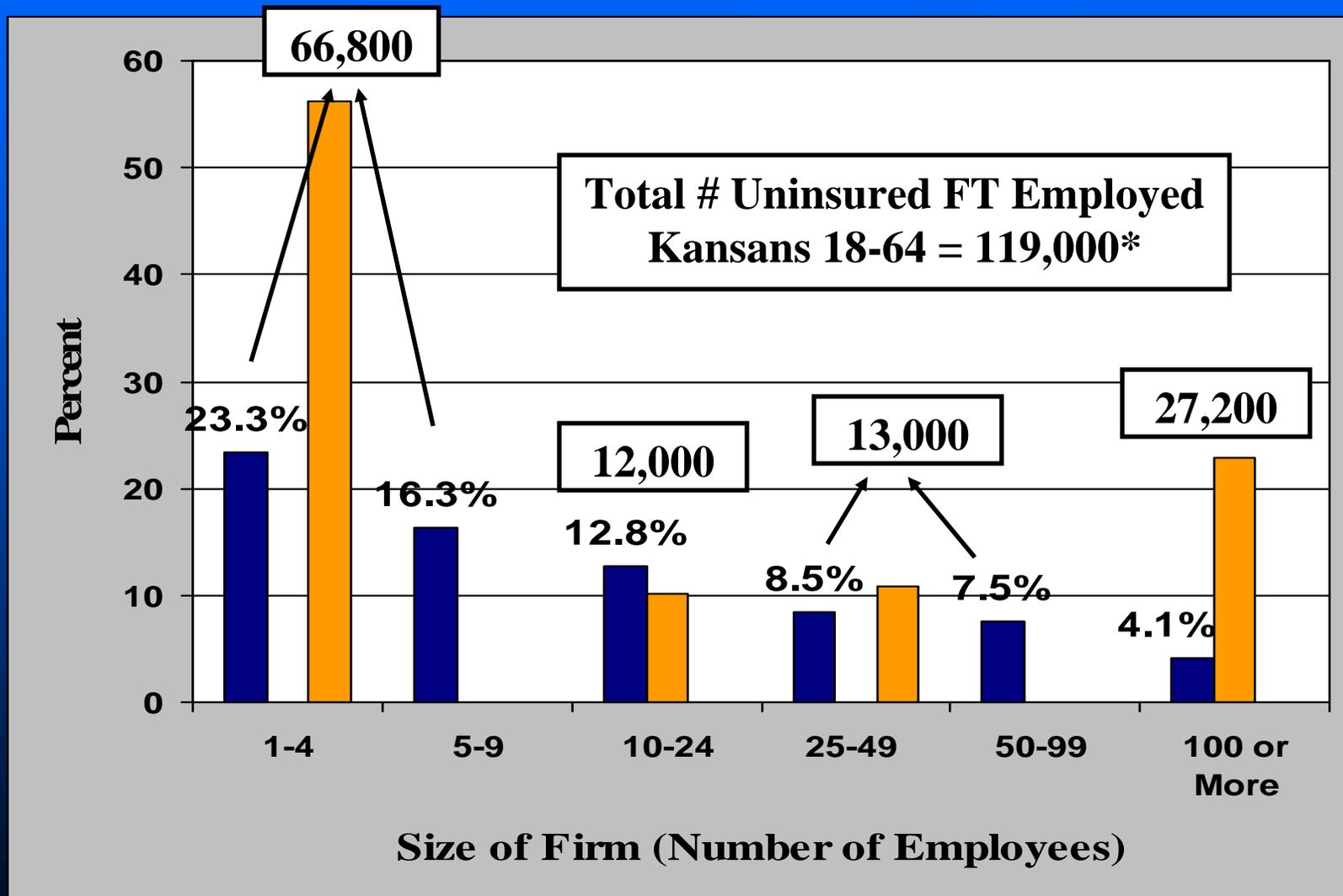
Uninsured Kansans under Age 65 by Income as a Percent of FPL and Distribution of Uninsured



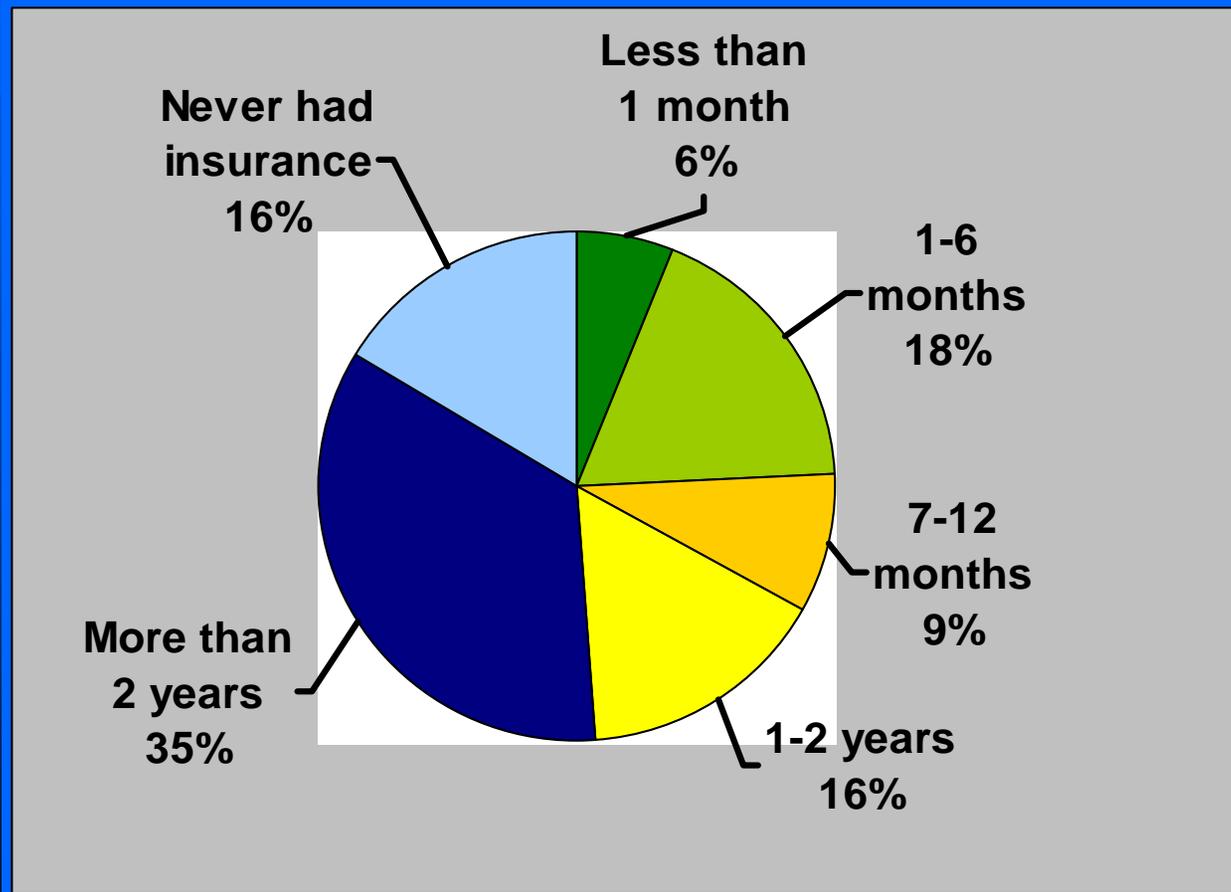
Uninsured Kansas Children Under Age 65 by Income as a Percent of FPL, and Distribution of Uninsured



Uninsured Full-Time Employed Kansans Age 18-64 by Size of Firm



Length of Time Without Health Coverage: Uninsured Kansans Under Age 65



KHPA Board 2007 Health Reform Recommendations

Submitted to the Governor and
Legislature on November 1, 2007

KHPA Reform Priorities

– Promoting personal responsibility (P1)

- Responsible health behaviors
- Informed purchase of health care services
- Contributing to the cost of health insurance, based on ability to pay

– Prevention and medical homes (P2)

- Focus on obesity, tobacco control, chronic disease management and incentives for primary care medical homes

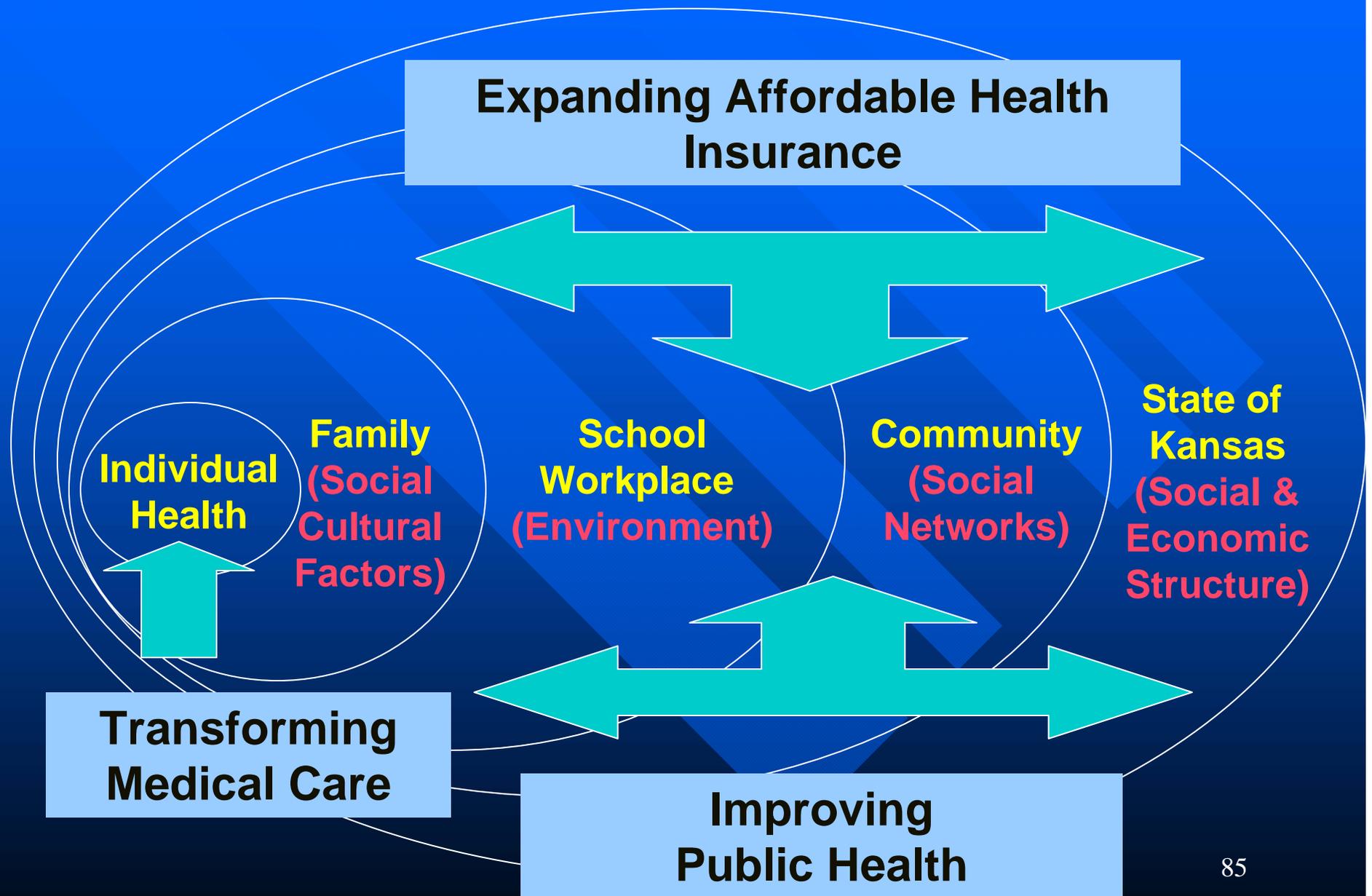
– Providing and protecting affordable health insurance (P3)

- Focus on small businesses, children, and the uninsured

Priorities: System Reform and Better Health

Transforming Medical Care	Improving Public Health	Expanding Affordable Insurance
<ul style="list-style-type: none"> ■ Transparency project: health care cost and quality ■ Health literacy ■ Medical home definition ■ Medicaid provider reimbursement ■ Community Health Record (HIE) ■ Form standardization 	<ul style="list-style-type: none"> ■ Increase tobacco user fee ■ Statewide smoking ban ■ Partner with community organizations ■ Education Commissioner ■ Collect fitness data in schools ■ Promote healthy foods in schools ■ Increase physical fitness ■ Wellness for small businesses ■ Healthier food for state employees ■ Dental care for pregnant women ■ Tobacco cessation in Medicaid ■ Expand cancer screening 	<ul style="list-style-type: none"> ■ Aggressive outreach and enrollment of eligible children (target population: 20,000) ■ Premium assistance for low income adults without children (target population: 39,000) ■ Small business initiatives (target population: 15,000 young adults and 12,000 employees of small businesses)

Socioeconomic Framework for Health Status



Promoting Personal Responsibility

Personal Responsibility Policy Options (P1)

■ Improve Health Behaviors

- Encourage healthy behaviors by individuals, in families, communities, schools, and workplaces
- Policies listed under P2 – pay for prevention

■ Informed Use of Health Services

- Transparency for consumers – health care cost & quality transparency project
- Promote Health Literacy

■ Shared Financial Contributions for the cost of health care

- Policies listed under P3

“We need to have a renewed focus on personal responsibility of health care. We cannot have a solution until we change our culture of miracle medicines.”

-- KC Chamber of Commerce Member

Promoting Medical Homes

Medical Home Policy Options (P2)

Promote “Medical Home” Model of Care

- Define medical home
- Increase Medicaid provider reimbursement for prevention/primary care
- Implement statewide Community Health Record
- Promote insurance card standardization

“It’s difficult for a provider to code for Medicaid for obesity counseling. Insurance won’t pay for it. They pay for the diabetes but not the counseling and so people won’t come to the doctor until they have the chronic disease because they have to pay the doctor bill themselves.”

--Emporia Provider at Flint Hills Community Health Center

Paying for Prevention:

Families, Communities, Schools,
and Workplaces.

Pay for Prevention Policy Options (P2)

■ Healthy Behaviors in Families & Communities:

- Increase tobacco user fee
- Statewide Smoking ban in public places
- Partner with community organizations

■ Healthy Behaviors in Schools:

- Include Commissioner of Education on KHPA Board
- Collect information on health/fitness of Kansas school children
- Promote healthy food choices in schools
- Increase physical education

Summary: Pay for Prevention Policy Options (P2 Cont.)

- **Healthy Behaviors in Workplaces:**
 - Wellness grant program for small businesses
 - Healthier food options for state employees
- **Additional Prevention Options:**
 - Provide dental care for pregnant women
 - Improve tobacco cessation within Medicaid
 - Expand cancer screenings

“The most pressing issue is people taking responsibility for living healthy lifestyles. It’s not a health care crisis. It’s a health crisis.”

-- Winfield health care provider

*Providing and Protecting
Affordable Health Insurance*

Provide & Protect Affordable Health Insurance Policy Options (P3)

■ Three targeted initiatives

- Expand private insurance for low-income Kansans through premium assistance program: **Kansas Healthy Choices**
- Improve access to coverage for Kansas children, with specific targets for enrollment
- Increase affordable coverage for solo business owners and other small businesses

“Many gamble. Can you forego health insurance in order to buy land, or farming equipment, or feed [your] family? Many families know it’s not responsible, but they are forced to make that decision.”

--Reno County farmer

Insurance for Low-Income Kansans: Premium Assistance

- **Details.** Expansion population for the premium assistance program – Childless adults earning up to 100% FPL (\$10,210 annual income)
- **Population Served.** Estimated 39,000 low-income Kansas adults.
- **Estimated Cost.** \$56 million SGF

Improve Access to Care for Kansas Children

- **Details.** Aggressive targeting and enrollment of children eligible for Medicaid & HealthWave; includes specific targets and timelines for improved enrollment.
- **Population Served.** Estimated 20K Medicaid & HealthWave eligibles
- **Estimated Cost.** \$14 million SGF

Increase Affordable Coverage for Small Businesses

- Encourage **Sec. 125 plans**
- Develop a “**voluntary health insurance clearinghouse**”
- Define small group market and **provide reinsurance**: obtain grant funding for further analysis
- **Young adult policies** - dependent coverage age extension and development of targeted young adult insurance products
- Pilot projects – support grant program in the Dept of Commerce for **small business health insurance innovations**

Priorities: System Reform and Better Health

Transforming Medical Care	Improving Public Health	Expanding Affordable Insurance
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Future of Health Reform in Kansas

Financing Health Reform

- Fifty cent increase in tobacco user fee
 - Estimate of **\$69.7 million annually**
- Increased federal matching dollars
- Hidden tax in Kansas – cost shifting
 - As much as 7%
- Cost containment - built into majority of proposals

“In advancing these recommendations to the Governor and legislature, the KHPA Board focused on improved health for Kansans, first and foremost. We hope that this health reform package -- with recommendations for promoting personal responsibility, encouraging prevention, and advocating the use of medical homes, together with significant improvements in access to health insurance -- offer meaningful, actionable health reform”.

-- KHPA Board 2007 Health Reform Recommendations

Kansas-Specific Needs:

Insights from Listening Tours/Advisory Councils

- 20-city, 35-event listening tour to gather firsthand feedback from over 1000 Kansans
- Advisory councils – Consumer, Provider, Purchaser, At large
- Highlights of Relevant comments/recommendations:
 - Support evidence based medicine in health plans
 - Encourage the use of cost-effective health care services by putting buying power in individuals' hands
 - Support for using HIT to foster public reporting and transparency. It will improve quality, actively engage consumers, and drive down costs
 - Health reform should focus on most at-risk population
 - Health insurance should be affordable to everyone – include all health care costs to determine what is affordable – incl. premiums, deductible, prescriptions, etc.
 - To better manage chronic diseases, health plan benefit design should include health screen assessments, evidence-based practices, case management, disease management, and medication management options

Planned Reporting

Potential Benefits of Public Reporting

(www.commonwealthfund.org)

■ Consumers:

- Could use this information at various points of interaction with the health system,
- From the time they choose a health plan to the point of selecting a health care provider for a specific service

■ Employers/Purchasers:

- Could select from among various health plans or self-insured options
- Compare the cost and outcomes, e.g., to market averages
- Evaluate the plan's record of performance in meeting service and quality standards.

Potential Benefits of Public Reporting

(www.commonwealthfund.org)

■ Health plans:

- Though health plans have access to their own claims data, in certain markets they may not have sufficient information to evaluate the price and quality of all physicians, hospitals, and other providers, e.g., at the market level
- May want to benchmark their performance on service and quality measures to their competitors.

■ Providers:

- Hospitals, physicians, nursing homes, and other health care providers would benefit from more transparent price and quality information as a feedback loop for improved performance
- Could identify the most efficient and effective referrals

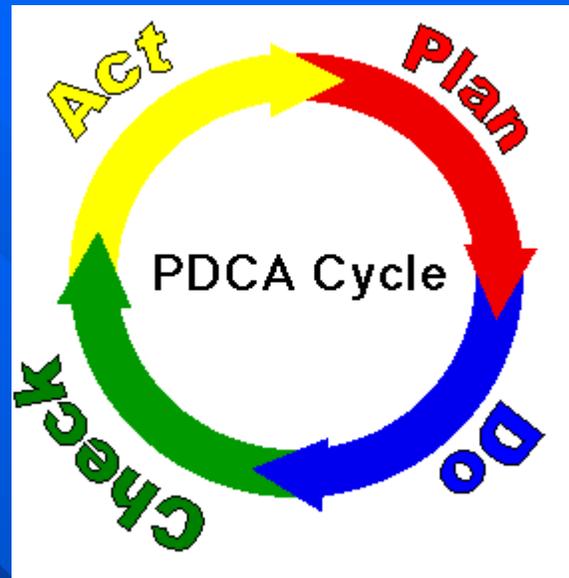
Potential Benefits of Public Reporting

(www.commonwealthfund.org)

■ Policymakers:

- Helpful to federal and state officials with responsibility for oversight and monitoring of system performance
- Accurate and timely information on providers and health plans useful to monitor changes in the overall system
- Would be able to use the info to encourage the reporting groups to monitor their own performance
- Extends policy and program design discussions to a wider range of stakeholders

PDCA Methodology



Rapid cycle, Continuous Quality Improvement technique conceived by Walter Shewhart in 1930 & later adopted by Edward Deming

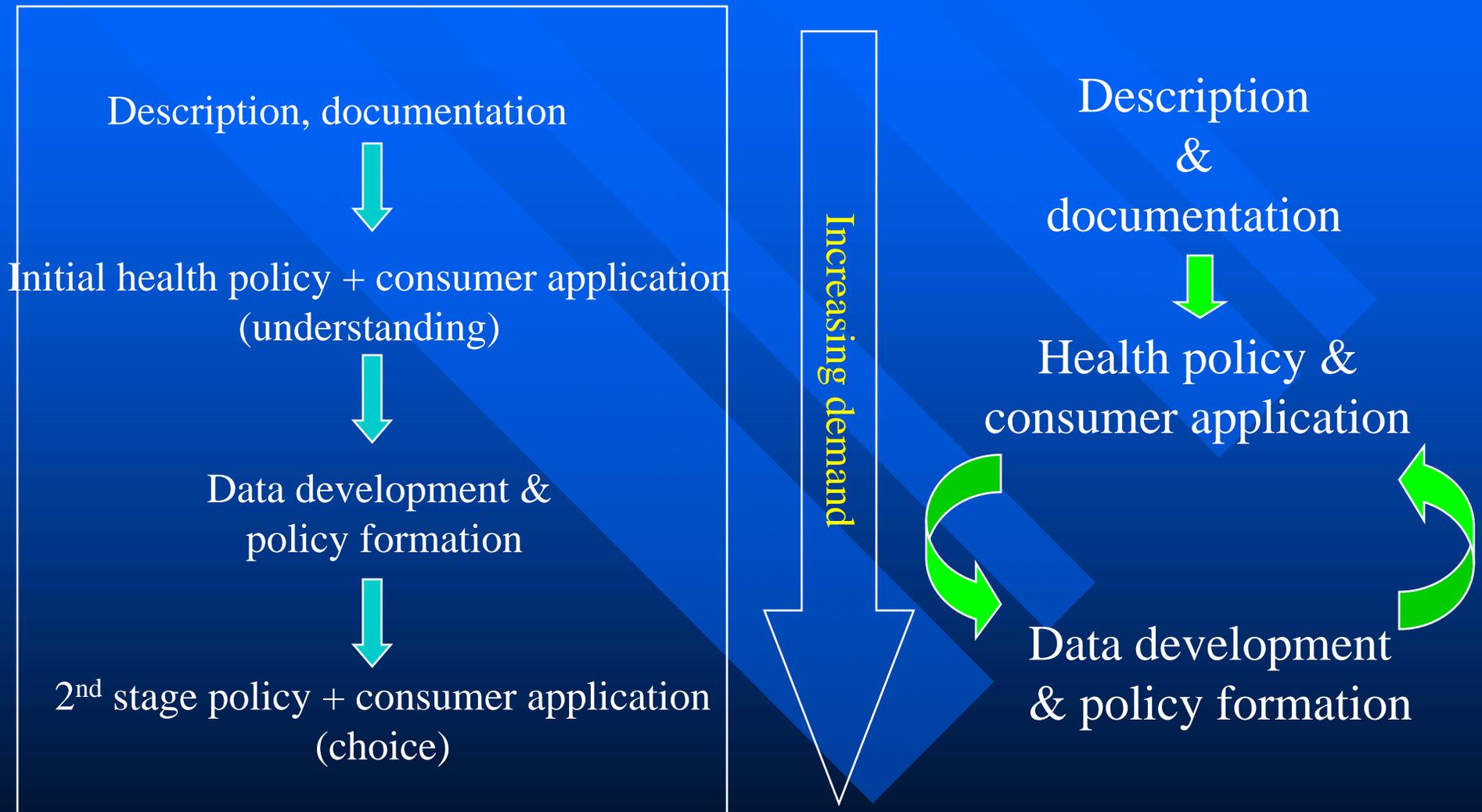
Plan – the process improvement steps

Do - implement the planned steps (initially on a small scale, if desired)

Check – the results. Did it work or not? Lessons learned.

Act – Adopt (Hardwire) or abandon the change or run through the PDCA cycle again

Data Use & Policy Process



Core Task for the Data Consortium



Vision Principles & Health Indicators

- Adopted by the Board in 2006
- Provides governance and operational direction to the Board
- Provides guiding framework to analyze health reform options
- Provides “yardstick” to measure over time improved health in Kansas

Quality and Efficiency

Affordable, Sustainable Health Care

Access to Care

- Health Insurance Status
- Health Professions Workforce
- Safety Net Stability
- Medicaid Eligibility
- Health Disparities

- Use of HIT/HIE
- Patient Safety
- Evidence based care
- Quality of Care
- Transparency (Cost, Quality, etc.)

- Health insurance premiums
- Cost-sharing
- Uncompensated Care
- Medicaid/SCHIP Enrollment
- Health and health care spending

KHPA: Coordinating health & health care for a thriving Kansas

- Physical Fitness
- Nutrition
- Age appropriate screening
- Tobacco control
- Injury control

- Open Decision Making
- Responsible Spending
- Financial Reporting
- Accessibility of Information
- CMS Cooperation

- Council Participation
- Data Consortium
- Public Communication
- Community/Advocacy Partnership
- Foundation Engagement

Health and Wellness

Stewardship

Public Engagement

SRS

- Mental Health
- LTC for Disabled
- Substance Abuse

KDHE

- Health Promotion
- Child, Youth & Families
- Consumer Health
- Health & Envir. Statistics
- Local & Rural Health

KDOA

- Aged
- Institutional Care
- Community Care

KID

- Private Health Insurance
- Business Health Partnership¹⁵

Access to Care

Kansans should have access to patient centered health care and public health services which ensure the right care, at the right time, and at the right place.

■ Indicators:

- (1) Health insurance status;
- (2) Health professions workforce;
- (3) Safety net stability;
- (4) Medicaid eligibility;
- (5) Health disparities

Quality and Efficiency

The delivery of care in Kansas should emphasize positive outcomes, safety and efficiency and be based on best practices and evidence-based medicine.

■ Indicators

- (1) Use of Health Information Technology/Health Information Exchange;
- (2) Patient Safety;
- (3) Evidence based care;
- (4) Quality of care;
- (5) Transparency (of cost and quality of health information).

Affordable & Sustainable Health Care

The financing of health care and health promotion in Kansas should be equitable, seamless, and sustainable for consumers, providers, purchasers, and government.

■ Indicators

- (1) Health insurance premiums;
- (2) Cost sharing by consumers;
- (3) Uncompensated care;
- (4) Medicaid and SCHIP enrollment;
- (5) Health and health care spending.

Health and Wellness

Kansans should pursue healthy lifestyles with a focus on wellness as well as a focus on the informed use of health services over their life course.

■ Indicators

- (1) Physical fitness;
- (2) Nutrition;
- (3) Age appropriate screening;
- (4) Tobacco control;
- (5) Injury control.

Responsible Stewardship

The KHPA will administer the resources entrusted to us by the citizens and the State with the highest level of integrity, responsibility and transparency.

■ Indicators

- (1) Open decision making;
- (2) Responsible spending;
- (3) Financial reporting;
- (4) Accessibility of information;
- (5) Cooperation with the Centers for Medicare and Medicaid Services—our federal partners for the Medicaid and SCHIP programs.

Education & Engagement of the Public

Kansans should be educated about health and health care delivery to encourage public engagement in developing an improved health system for all.

■ Indicators

- (1) Advisory Council Participation;
- (2) Data Consortium Participation;
- (3) Public communication;
- (4) Community/Stakeholder/Advocacy Partnership;
- (5) Foundation Engagement.

Desirable Characteristics of Health Measures

- Reliability (Inter-rater, repeated measure)
- Validity
- Measurable at state and national levels to enable comparisons
- Measured on regular basis to monitor progress

Data Consortium Structure and Governance

Structure and Governance

- Advisory Committee to KHPA Board
(Section 3c of SB 272)
- Scope of responsibility defined in Charter Statement, but may be revised by KHPA at its discretion
- Executive Director (or designee) as Chair
- Robert's Rules of Order unless alternative procedures adopted by Consortium

Structure and Governance

- To meet diverse responsibilities, Board recommends 3 working groups:
 1. Health Care Quality
 2. Health Care Pricing
 3. Public Health/Consumer Info
 - *Other grouping (e.g. by vision principle) also a possibility*
- Board authorized the Consortium and 3 work groups to meet as many as 6 times/yr

Next Steps

Tasks Ahead

- Map standardized measures to the indicators of the 4 vision principles:
 - » Affordable, sustainable health care
 - » Access to care
 - » Quality and efficiency
 - » Health and Wellness
- Coordinate with current initiatives in other agencies and organizations
- Create strategy for capacity-building and staffing for routine reporting
- Others ?



KHPA

Kansas Health Policy Authority

Coordinating health & health care for a thriving Kansas

<http://www.khpa.ks.gov/>