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Testimony on:
Budget Update for the Kansas Health Policy Authority

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House Appropriations and Senate Ways and Means Joint Committees
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Budget Update for the Kansas Health Policy Authority

Good afternoon Mr. Chairman and members of the Committee. I am Marcia Nielsen, Executive Director of the Kansas Health Policy Authority. I appreciate this opportunity to provide a budget update to the House Appropriations and Senate Ways and Means Committees as it pertains to the Medicaid, HealthWave, and State Employee Health Benefits Plan (SEHP) programs. A packet of information has been provided to each committee member which includes slides on expenditure trends for fiscal year (FY) 2007, FY 2008, and FY 2009, and slides on the five FY 2009 budget enhancement requests (three programs, and two on-going pilot programs) that were approved by the KHPA Board in September is briefly summarized. Additionally, the executive summary for the KHPA Board health reform recommendations is also included in your packet.

This testimony will describe in detail the three program budget enhancement requests, and the two pilot program continuation enhancement requests that were submitted to the Governor in September.

I. PREMIUM ASSISTANCE IMPLEMENTATION (KANSAS HEALTHY CHOICES)

Description: Senate Bill 11 authorized KHPA to pursue development of a premium assistance program for low income families. The 2007 Legislature added \$1.0 million to the KHPA FY 2008 budget to begin implementation of premium assistance. Enrollment in the participating health plans will begin for the first families eligible for premium assistance in January 2009. This will require funding for the assistance offered to families, contract amendments for eligibility determination and enrollment in health plans, and additional staff resources within KHPA.

Background: Premium assistance uses state and federal Medicaid funds to subsidize the purchase of private health insurance, either through employer sponsored health insurance or through a state procured private health insurance plan. Some states are moving toward this model to encourage low-income families to participate in private health insurance coverage, shore-up the private coverage market and prevent crowd-out, reduce cost-shifting in the private marketplace by reducing the number of uninsured, and achieve cost savings by bringing in employer contributions to help offset costs.

Premium assistance in Kansas, which will be called Kansas Healthy Choices, will be phased in over four years, with a “legislative trigger” to evaluate the program and ensure that adequate funding is available. It will be implemented in two ways:

- **Employer-sponsored insurance (ESI) buy-in:** For low-income uninsured parents who have access to employer sponsored private health insurance, Medicaid would pay the employee share of the health insurance premium for families, and then, “wrap around” children’s coverage with fee for service Medicaid.
- **Competitively bid state-procured health plans:** For low-income uninsured families, Medicaid (state and federal share) would pay for premiums for state procured private health insurance to be offered to low-income children and their parents. Because children eligible for Medicaid are required by federal law to

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receive certain services, the private insurance plans would be supplemented by “wrapping around” private health insurance coverage with Medicaid benefits.

The phase in of premium assistance is scheduled to begin with families under 50.0 percent of the federal poverty level in January 2009. Current Medicaid eligibility only covers adults up to 37.0 percent of the federal poverty level. During FY 2008, KHPA will develop the specifications for the health plans, eligibility criteria, and the necessary Medicaid state plan amendments to implement premium assistance. Three staff positions were included in the FY 2008 budget to develop and manage the program, including eligibility and payment system changes, outreach and enrollment materials, and program manuals.

The following table describes the additional resources needed to begin implementation in FY 2009.

Administrative costs for premium assistance FY 2009

Contract Costs	SGF	Federal Funds	All Funds
HIPPS (Health Insurance Purchase Program)	175,000	175,000	350,000
Eligibility Contractor KHPA	250,000	250,000	500,000
Enrollment in health plans through the MMIS system. (new staff and volume)	325,000	325,000	650,000
External Quality Review Organizations costs based on 1 added	300,000	300,000	600,000
State eligibility Clearinghouse staff (4 FTE)	97,500	97,500	195,000
Managed Care State Staff (2 FTE)	32,500	32,500	65,000
Non-recurring from FY 2008	(142,500)	(142,500)	(285,000)
Caseload	4,000,000	6,000,000	10,000,000
Total	5,037,500	7,037,500	12,075,000

This request includes \$1.5 million in additional contractual payments to the fiscal agent and Clearinghouse contractors to evaluate families’ eligibility for premium assistance or the employer health insurance buy in program, assist families in connecting to the most appropriate health insurance product, and enroll in the selected health plan. The cost of monitoring and evaluating the quality and performance of additional health

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plans will cost an additional \$600,000 and needed MMIS changes to make payments and capture encounter data will cost \$300,000. The enhancement request also includes salary for additional state staff at the Clearinghouse to determine eligibility and 6 months of salary for Managed Care program staff to provide oversight of the new health plans.

Population Served: 8,500 low income parents.

Cost Estimate: KHPA is requesting an enhancement of \$12.1 million, including \$5.0 million from the State General Fund, for contract changes, administrative costs, and half year salaries for 6.0 state FTE positions. The cost of premium assistance for newly eligible beneficiaries (the expansion population) for FY 09 is estimated to be \$10.0 million, including \$4.0 million from the State General Fund.

II. PROCUREMENT OF AN INTEGRATED ELIGIBILITY AND ENROLLMENT SYSTEM

Description: KHPA needs to procure an enrollment system that is capable of accommodating all of the agency's enrollment functions, including private and public health insurance programs.

Background: KHPA is statutorily charged with responsibility for Medicaid eligibility policy and eligibility and enrollment in the State Employee Health Plan (SEHP). Currently KHPA uses two systems that are maintained by separate agencies, the eligibility system maintained by Social and Rehabilitation Services (SRS) and employee enrollment system maintained by the Department on Administration. The SRS system is 20 years old, designed to manage the state's welfare programs, and no longer meets the needs of either agency. System changes are expensive, cannot keep pace with Medicaid eligibility policy, and require KHPA staff to expend significant staff hours to manually "work-around" the SRS system.

KHPA's strategy to increase participation in the Medicaid, HealthWave and SEHP health plans, especially for uninsured children, includes leveraging community resources such as places of worship and clinical settings statewide. The current system does not support web-based applications, limiting where it can be accessed. KHPA is under a legislative mandate to lead health reform options in Kansas to improve the health outcomes of all Kansans. To achieve this goal in an efficient and cost-effective manner, KHPA and SRS are seeking to collaborate in re-procuring an eligibility and enrollment system, allowing KHPA to align its enrollment functions with private health industry models, build an administrative infrastructure that supports data driven management and policy making, and allow for easily connecting eligible individuals with SRS' services.

Population Served: Individuals and families who are eligible for the following federal or state programs: Medicaid, SCHIP, MediKan, TB, Breast and Cervical Cancer, Healthy Kids, Medicare Supplemental Savings Programs, Child Welfare programs, SOBRA, ADAP and State Employees Health Plan members, and the uninsured Kansans at large. Total estimated number of individuals: 388,000.

Cost Estimate: The total cost request for the KHPA is approximately \$20.0 million; SRS will also be requesting funds for their portion of the integrated enrollment system. The KHPA project plan calls for a three year design and implementation timeframe. For FY 2009, KHPA is requesting an additional \$8.0 million, including \$4.0 million from the State General Fund, to implement the medical eligibility component by July 2010. The FY 2010 budget request will total \$10.0 million, including \$5.0 million from the State General Fund, for the remaining development, and the FY 2011 budget would include \$2.0 million to pay for the final

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implementation costs after successful delivery of the product.

The estimated ongoing operational costs of the new system would be approximately \$3.9 million annually. These costs include \$2.0 in licensing fees, as well as \$1.2 million for system maintenance, user support, and subsidiary systems such as imaging and workflow management costs. There would be some direct costs of operating the system, such as printing and mailing of notices and providing network connectivity that would total \$550,000. These could be state costs or costs passed through the contract.

While the majority of the ongoing operational costs would be paid to the system contractor, KHPA would need at least one staff member to manage system security (approximately \$61,620) and user access.

Cost Estimate:

Contract Costs	SGF	Other Funds	Total
Year One	4,000,000	4,000,000	8,000,000

Considerations:

- KHPA’s medical eligibility needs have changed so that medical policy aligns more with private insurance than welfare programs.
- The system needs to integrate with existing health care data repositories to make data-based policy decisions.
- Information technology has drastically improved over the last 20 years. A modern, agile system will allow necessary modifications, to support medical program changes, to be initiated quickly and completed at a minimum of cost, and will facilitate a community-oriented web-based approach to outreach.
- When changes to our enrollment processes occur, such as adding or altering programs or changing eligibility requirements, it is difficult to modify the current system because of its age. The required modifications are often difficult to make, cannot be completed in time to meet legislative deadlines, and are unusually costly. These challenges often result in the substitution of system changes with error-prone and costly manual processes that are difficult to record, track, review, and modify.
- The cumbersome nature of the current eligibility system lowers worker productivity and increases both agencies’ administrative costs, particularly when system access has to be shut off to conduct regular maintenance during peak processing periods.
- The current system produces little information of value to policymakers and managers seeking to optimize eligibility policy and improve performance of the enrollment system. Data inquiries are difficult to program and are essentially inaccessible to those responsible for primary outcomes.
- The State Employees Health Program is experiencing similar challenges with their current membership and enrollment system, leaving state employees poorly-served.
- A new system will allow KHPA to model our programs on the health industry instead of the public assistance model.
- Incorporating the State Employee Health Program enrollment process into this system will allow KHPA to integrate enrollment and membership management needs thereby creating efficiencies within the enrollment processes and information dissemination.
- Any new enrollment system will need to facilitate continued communication and daily cooperation between KHPA, SRS and Department of Administration staff.

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III. AUTOMATING THE PRESCRIPTION DRUG PRIOR AUTHORIZATION SYSTEM

Description: Provide funding for an automated pharmacy Prior Authorization (PA) system as an FY 2009 enhancement.

Description: Kansas Medicaid currently operates a manual Prior Authorization (PA) system for pharmaceuticals, which requires a review of certain prescription drugs by a trained health provider before the pharmaceutical is authorized. All PA requests in the Kansas Medicaid program are currently submitted by mail or fax and simple requests are reviewed by nurses. A pharmacist is used for reviews that fall outside of the established criteria. The criteria for approving the PA requests easily could be programmed into an electronic system, thereby offering the potential for greater efficiency to the Medicaid program. With nearly 6,000 PA requests annually and approximately 80.0 percent of PA requests being approved, clinical pharmacists and other quality assurance personnel could spend their time more productively in managing other aspects of the Medicaid drug program. Additionally, electronic clinical and fiscal editing would allow Medicaid to expand the number of claims that are reviewed through the system without an undue administrative burden on providers or the state.

Background: This option would allow Kansas Medicaid to secure a contract with a vendor to develop a statewide automated prior authorization system that could be accessed at the point of care by pharmacists. Efficiencies gained through this technology could then be used to increase control over medication use and costs and enhance the cost-effective use of medications.

Automated PA programs intercept inappropriate claims during the point of sale transaction, while allowing claims that meet evidence-based guidelines to be paid and filled. A sophisticated automated electronic clinical and fiscal editing program will be integrated into the existing MMIS system. The system queries patients' medical and pharmacy claims history in real time to determine the appropriateness of therapies based on established best practices criteria. Pharmacists will receive real time notification, generally within seconds, of PA denials or requirements for additional information allowing them to select more appropriate therapy at the point of care.

Population Served: This option would be implemented statewide and would affect the entire Medicaid and HealthWave population.

Cost Estimate:

Contract Costs	SGF	Other Funds	Total
Automated PA	187,500	562,500	\$750,000
System EDS (MMIS changes)	18,750	56,250	\$75,000
Subtotal	206,250	618,750	\$825,000

Considerations: This is an estimate of the cost of contracting for an automated prior authorization system that pharmacists can access.

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IV. CONTINUING ENHANCED CARE MANAGEMENT (ECM) PILOT

Description: Build on the Sedgwick County Enhanced Care Management Program pilot by expanding to one additional region of the state during FY 2009 and re-assess for possible statewide implementation.

Description: Enhanced Care Management (ECM) is a pilot project to identify and provide enhanced administrative services to HealthConnect Kansas (HCK) members in Sedgwick County who have probable or predictable high future health care costs usually as a result of multiple chronic health conditions. The project is based on an Enhanced Primary Care Case Management (E-PCCM) Model which is member centered, provider driven, and based on a successful model in North Carolina.

The design of the ECM is unique in its approach to connecting providers and beneficiaries through community resources. The design is also closely aligned with chronic disease management models. Service delivery is community based and culturally appropriate with the goal of connecting beneficiaries to social and health care already available in the community. Eligible Medicaid beneficiaries are invited to receive services; participation is strictly voluntary. Because this population is socially isolated, ECM staff establishes relationships with members in their homes, using creative outreach techniques. Care managers assist members to focus on chronic health conditions, social risk factors and unhealthy lifestyle behaviors that adversely affect their health status. Intervention by ECM staff involves a person-centered approach, which focuses on assisting clients in accessing resources in the community, which will improve their health conditions.

The care management team consisting of a nurse and a social resource care manager as well as a physician (medical director) have responsibilities that include: assessing members' health and social needs; reviewing utilization trends; reconnecting members with their PCCM through scheduling and attending regular visits and if needed or requested the ECM staff accompany members to their medical appointments; ensuring members fill and take necessary prescriptions; developing comprehensive individualized care plans, which include member and provider-directed health care goals; with outlined steps for goal achievement; providing patient education in the home, teaching members how to manage their health conditions on a daily basis; assisting members to access community resources including safe and affordable housing, food, utility assistance, clothing, mental health and substance abuse services, credit counseling and others. The ECM program may also purchase health monitoring equipment including digital blood pressure monitors, weight scales and pedometers if prescribed by the PCCM. The ECM pilot project began service delivery in March 2006 under the leadership of the Sedgwick County Medical Society and the Central Plains Regional Health Care Foundation.

Although the pilot project has been operational for a year, data from the program are being evaluated and the final evaluation report (looking at both qualitative and quantitative data) will be available as part of the KHPA annual report in January 2008. After review of the evaluation, the KHPA will assess for possible statewide implementation incorporating lessons learned from the pilot.

Population Served: The focus population is Medicaid recipients with chronic health conditions and probable future high risk for expenditures of medical resources. This population is typically comprised of Social Security Income (SSI) recipients and excludes persons who are dually eligible for both Medicaid and Medicare, participating in a Home and Community Based Service (HCBS) waiver, reside in a Long Term Care (LTC) facility or are a participant in one of the two capitated Medicaid managed care organizations.

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Cost Estimate:

Contract Costs	SGF	Other Funds	Total
Continue pilot	50,000	50,000	100,000

The KHPA is asking for an enhancement of 50,000 (\$100,000) for FY 2009 to continue the project. The ECM will collect additional data for a cost-effectiveness evaluation before statewide implementation is considered. The costs to continue the ECM pilot for FY 2009 in Sedgwick County is approximately \$1.1 million All Funds. The FY 2007 expenditures for the contract were \$575,556 and the estimate for the full year of operations for FY 2008 is \$998,400.

Considerations:

- The current voluntary nature of the ECM program for Medicaid beneficiaries has led to slow enrollment in the pilot (as of June 2007, there were 181 members enrolled; that number continues to increase each month. More up to date numbers will be provided to the legislature in January 2009). Consideration to develop a mandatory program would significantly increase the number of participants; however, it would also require the submission of a Medicaid waiver and a review of project goals and objectives.

IV. EXPANDING COMMUNITY HEALTH RECORD PILOT

Description: Refine the model used in the Sedgwick County Community Health Record (CHR) pilot project and expand it to a rural health environment.

Background: Nearly two years ago, the State of Kansas implemented a pilot project engaging select managed care organizations and an information technology company to deploy community health record (CHR) technology to Medicaid managed care providers in Sedgwick County. The health record is built on administrative claims data and provides clinicians electronic access to claimed medical visits, procedures, diagnoses, medications, demographics, allergies and sensitivities, immunizations, vital signs, and lead screening and health maintenance data (includes Early and Periodic Screening, Diagnosis and Treatment [EPSDT] status).

The record also contains an e-Prescribing solution that enhances the clinician’s workflow, reduces the risk of medication error caused by inadequate or unavailable patient information, and increases safety and health outcomes associated with prescription generation. This component provides a drug interaction and contraindication tool as well. The prescriber may access formulary information and has the capacity to submit prescriptions to pharmacies electronically. The pilot CHR also recently linked information from beneficiaries participating in the Enhanced Care Management pilot program. The goal of the CHR pilot was to assess the value that health information exchange (HIE) could offer to Medicaid providers and beneficiaries.

Pilot statistics since the project’s inception (February 2006)

- The CHR was limited to 20 provider sites throughout Sedgwick County and now includes 500 trained users.
- Measures collected by the vendor included
 - Patient Searches - 18,000 (includes front-desk users)
 - Chart Opens - 14,000
 - Completed Kan-Be-Healthy (EPSDT) Screening Forms - 1,100

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- E-Prescribing - 630 Scripts (88 trained users, 30 active users)
- 50% of the sites utilized the e-prescribing component
- 5,205 unduplicated beneficiaries' records were accessed by the 215 CHR providers in Sedgwick County in 2006

A recently completed evaluation recommends some enhancements and an expansion of the CHR to additional sites, incentives to clinicians to use the CHR, and specific targeting to sites like family practice and primary care clinics that perceived the most benefit from CHR and the e-prescribing tool. The independent physician end-user survey data was positive, particularly in community health settings.

Distinct from this pilot but built on the same CHR platform, the State Employee Health Benefit Plan currently is initiating participation in an employer-based community health record in the Kansas City area, which is home to about 11,000 state employees. The vendor and system features will mimic those available in the CHR, with the addition of consumer access to their own medical information.

Population Served: Medicaid beneficiaries and providers in Sedgwick County and an additional rural county, yet to be determined.

Costs:

Contract Costs	SGF	Other Funds	Total
Continue pilot	50,000	50,000	100,000

The KHPA is asking for an enhancement of 50,000 (\$100,000) for FY 2009 to continue the project and expand into a rural county, link the CHR to Enhanced Care Management program. This would test the efficacy of both the care management and interoperable health record model to improve the quality of care and health outcomes. The current contract for FY 2008 is \$250,000, including \$125,000 from the State General Fund.

Conclusion

I appreciate the opportunity to provide you with this detailed information on our FY 2009 Budget Enhancements. As part of our annual report submitted to the legislature at the beginning of the 2008 legislative session, I look forward to providing you with additional information on the significant strides made by our agency in 2007 in the areas of efficient health care purchasing, advancing health promotion and disease prevention, promoting data driven health policy, and coordinating health and health care for the State of Kansas. We are also anticipating a rigorous and thoughtful discussion of the KHPA Board health reform recommendations during the up coming session. This concludes my testimony. Andy Allison, KHPA Deputy Director and Medicaid Director and Scott Brunner, KHPA Chief Financial Office and I are happy to answer any questions

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