

Coordinating health & health care
for a thriving Kansas



**KHPA FY 2009 Budget Enhancement Requests
Fact Sheet**

Presented by Dr. Marci Nielsen, Executive Director

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1. Kansas Healthy Choices (Premium Assistance)

Background: Although children in Kansas are eligible for Medicaid or HealthWave up to 200 percent of the federal poverty level (FPL), Kansas currently has one of the lowest rates of Medicaid eligibility in the nation for poor parents (below 37 percent of the FPL1).

Premium assistance is the use of public, employer, and potentially individual contributions to purchase private health insurance for Kansas families living in poverty who cannot otherwise afford coverage. Kansas Healthy Choices (KHC) is the program name for the initiative authorized by Senate Bill 11 to use premium assistance to provide access to a range of private health insurance options to eligible families. The program applies minimal restrictions on families' purchase of private insurance, while ensuring:

- State access to 60% Federal matching funds;
- Lower costs as compared to both private insurance and more comprehensive Medicaid coverage;
- Access to affordable healthcare for families living in poverty;
- Protection of benefits to those currently eligible for HealthWave;
- Coverage for newly eligible parents on a par with private insurance plans;
- Coverage under one plan for each member of the family;
- Continuing access to a primary care medical home.

Insurance options under Kansas Healthy Choices

Families eligible for Kansas Healthy Choices will receive private coverage through one of the following mechanisms (*subject to pending Federal approvals*):

- Employer sponsored insurance (ESI) buy-in: For families with access to employer sponsored private health insurance, the state would pay the employee share of the health insurance premium for families.

Rm. 900-N, Landon Building, 900 SW Jackson Street, Topeka, KS 66612-1220

www.khpa.ks.gov

Medicaid and HealthWave:

Phone: 785-296-3981
Fax: 785-296-4813

State Employee Health

Benefits and Plan Purchasing:
Phone: 785-368-6361
Fax: 785-368-7180

State Self Insurance Fund:

Phone: 785-296-2364
Fax: 785-296-6995

- Competitively bid state-procured health plans: For families without access to a qualifying employer plan, KHPA will provide a choice of three state procured health plans offering high-quality, cost-effective benefits. Basic benefits will be tied to the value of state employee benefits.
- Health opportunity account (HOA) pilot: Families in two counties (one urban and one rural) will have access to a pilot program testing the application of consumer-driven purchasing in a low-income population. A high-deductible health plan will be coupled with a funded health opportunity account to provide incentives for prudent, prevention-oriented health care choices.

Participation in Kansas Healthy Choices: KHC options will be available beginning in January 2009. Over three years, the program is expected to provide about 20,000 existing and 24,500 newly eligible caretaker adults and their children with the choice of private insurance options and a “medical home” model of health care services.

Cost Estimate: The FY 2009 Governor’s Budget Recommendation included \$4,000,000 SGF/\$10,000,000 AF for the implementation - assistance costs; and \$518,750 SGF/\$1,037,500 AF for the administrative costs. This would be the estimated cost for Phase I of this program in FY 2009 to provide health coverage to those families below 37% of the Federal Poverty Level (FPL).

Kansas Healthy Choices FAQ: For more details about this program, a ten-page FAQ is available at: www.khpa.ks.gov .

2. Procurement of an Integrated 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. KHPA has been working with SRS in a joint effort to ensure that the system meets the needs of both agencies.

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 the 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 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 reprocurring 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. By collaborating on the purchasing of an eligibility and enrollment system, both agencies will make the best use of funding to implement a foundation for the future visions of each agency.

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 members, and the uninsured Kansans at large. Total estimated number of individuals: 388,000

Cost Estimate: The estimated cost for procurement of a new system is \$45.0 million. KHPA has requested \$20.0 million for its part of the system. SRS is requesting \$25.0 million. These costs will be shared with the Federal government and spread over three years. For FY 2009, KHPA is requesting \$8.0 million (\$4.0 million SGF).

Considerations:

- KHPA's medical eligibility policy needs to align more with private insurance than with 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 its 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.

3. 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 System	187,500	562,500	\$750,000
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.

A proposal for this system was submitted in the form of a Transformation Grant and we will be notified of any subsequent grant award in September of 2007.

4. Expansion of the Enhanced Care Management Program (ECM)

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 holistic 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. Kansas Health Policy Authority (KHPA) contracted with a non-profit community health organization to administer the program. Original estimates of program costs and enrollment were not realized early in the implementation due to low enrollment of beneficiaries. This resulted in a renegotiation of the contract, resulting in reduced overall program costs. 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 in October 2007. 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 managed care organizations.

Cost Estimate: The estimated cost to continue the current pilot project in Sedgwick County through FY 2009 is \$50,000 SGF and \$100,000 AF.

Considerations:

- Funding the current project for an additional year, with the inclusion of an additional rural pilot site, would provide additional data for a more comprehensive evaluation in order to inform a potential statewide ECM roll-out.

- An additional cost that will need to be included in the rural expansion will be transportation for ECM members.
- 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). 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. (It also dilutes the evaluation data measuring program effectiveness.)

Final Board Action:

A motion was made for the KHPA Board to support recommendation to continue the Sedgwick County pilot project through FY 2009.

5. Community Health Record Expansion to Rural Environment

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. The health policy literature on Health Information Exchange suggests that "patients and providers most likely have the most to gain. Organizations such as regulatory agencies, research institutions, and others not considered here could benefit from aggregate information about care. However, those who depend in subtle ways on redundancy and excess could find such change costly"¹.

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
 - 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

An independent evaluation of the CHR varied considerably by site (resource document in board binder). The evaluation recommends 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 very positive.

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,

¹ Jan Walker, Eric Pan, Douglas Johnston, Julia Adler-Milstein, David W. Bates, and Blackford Middleton (2005). The Value Of Health Care Information Exchange And Interoperability. Health Affairs. January.

yet to be determined.

Costs: The Governor's Budget Recommendations for FY 2009 included \$50,000 SGF and \$100,000 AF for this enhancement request.

Considerations: The Sedgwick County CHR project was launched in February 2006 and an initial evaluation was done in July 2007. That evaluation suggested some improvements to the program as well as recommending that the CHR program be expanded to additional sites. The initial feedback on the program was encouraging and has high potential to be a valuable tool for providers delivering services to all Medicaid/Healthwave and State Employee Health Plan enrollees. Before a decision to adopt the CHR program statewide, midcourse modifications (i.e. inclusion of additional data sources) to improve the pilot project CHR should be made and the pilot CHR should be tested in a rural environment. In addition a process for statewide expansion should be developed with attention to the recommendations of the Controlled Substance Task Force related to e-prescribing and the feasibility of including Medicaid/Healthwave and State Employee Health Plan enrollees examined.

As part of building support for Health Information Technology/Health Information Exchange through a Community Health Record, significant stakeholder input is needed. Accordingly, the KHPA Board supports the creation an "HIT/HIE Advisory Council" to provide ongoing feedback about the development and implementation of a statewide HIE efforts, taking into account on the work of the Governor's Health Care Cost Containment Commission, the Health Information Exchange Commission, and the Kansas HISPC (Health Information Security and Privacy Collaboration) project. The HIT/HIE Advisory Council could also provide guidance on the means to provide education and technical support for health care providers interested in integrating health information technology into their practices. Consumer and provider input to this process will be critical.