



# **Joint Committee on Health Policy Oversight**

## **August 14, 2008**

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**Kansas Health Policy Authority**

# Objectives

- Review of health reform and 2008 legislative session
- Discuss next steps and lessons learned
- Implementation of Medical Home
- Community Health Record Pilots
- Overview of Medicaid Transformation Process
- Status State Employee Health Benefit Program



## KHPA Mission

To develop and maintain a coordinated health policy agenda that combines the **effective purchasing and administration of health care with promotion oriented public health strategies**



# The Purpose of Health Reform

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

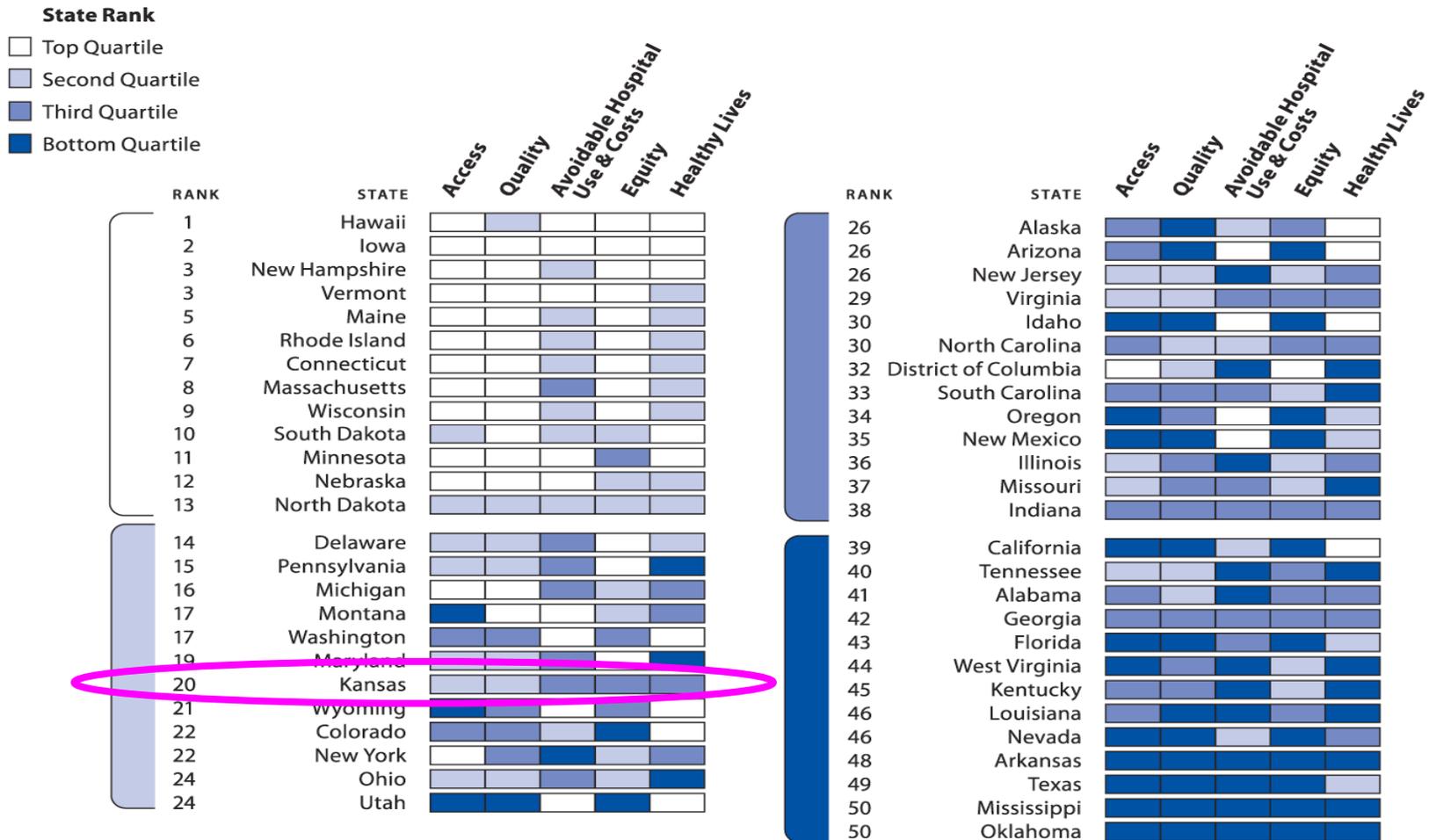


# Identifying the Issues

Problems in the health and health care system in Kansas

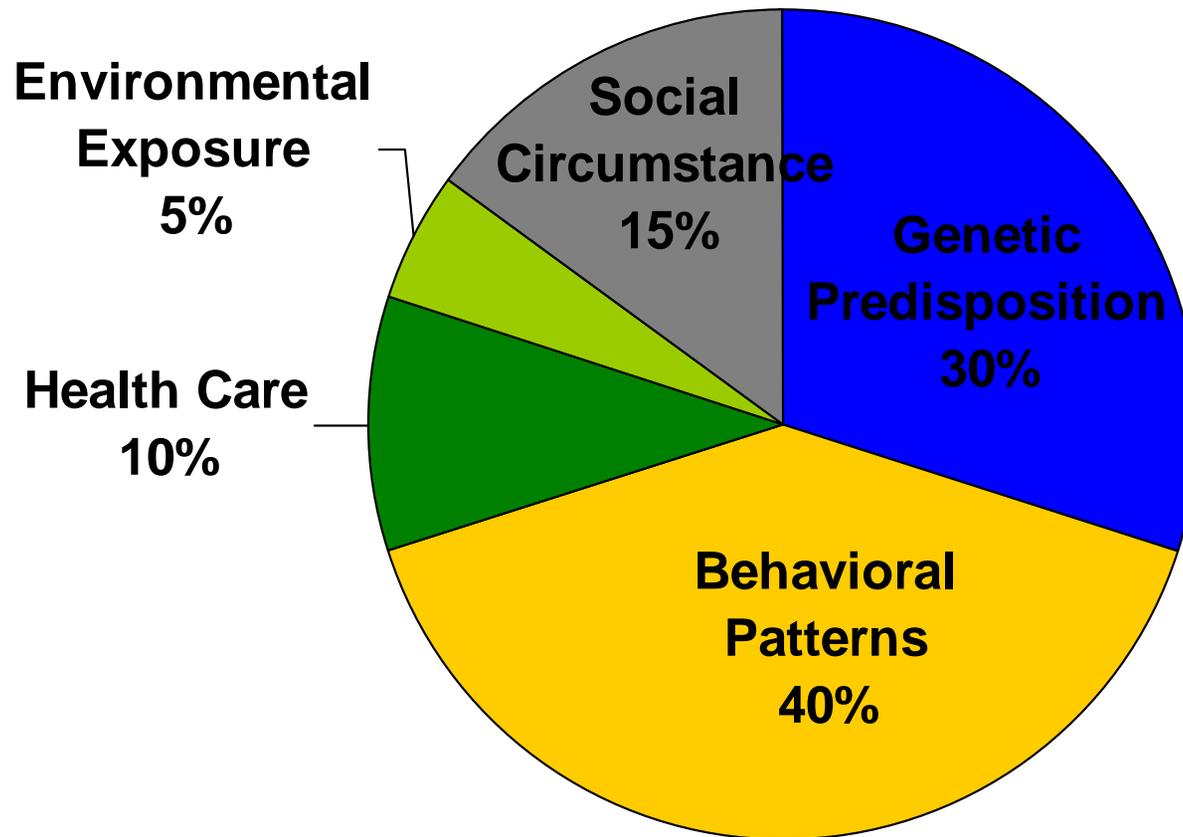
# Health of Kansas: Room for Improvement

## State Scorecard Summary of Health System Performance Across Dimensions



# Determinants of Health Status

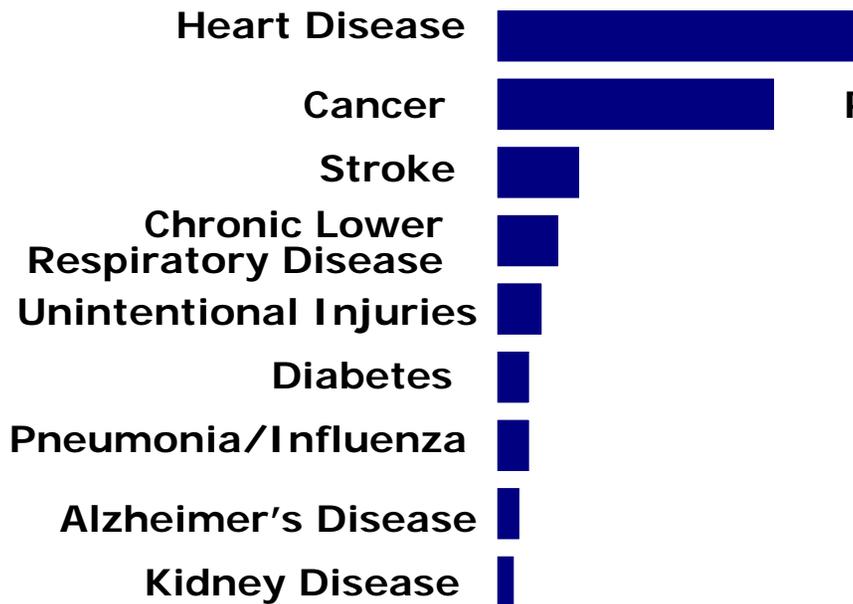
## Proportional Contribution to Premature Death



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

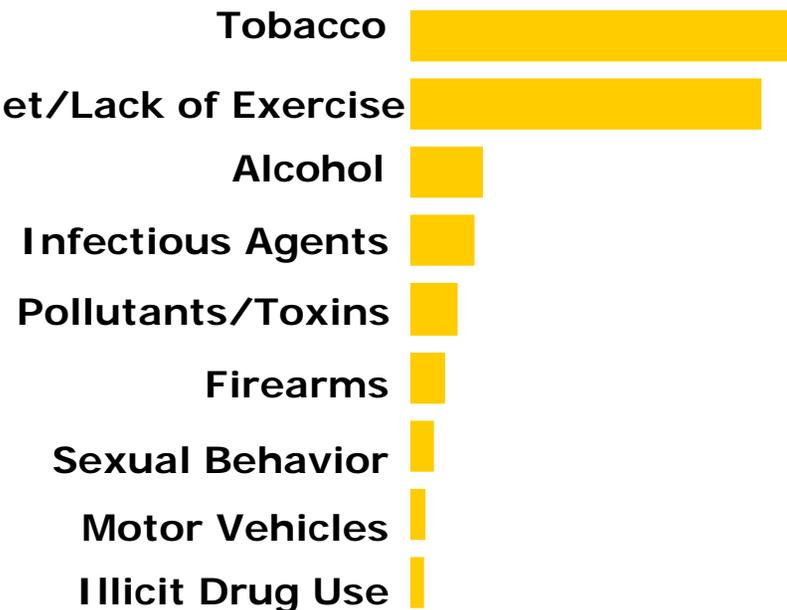
# Causes of Death United States, 2000

## Leading Causes of Death\*



Percentage (of all deaths)

## Actual Causes of Death†



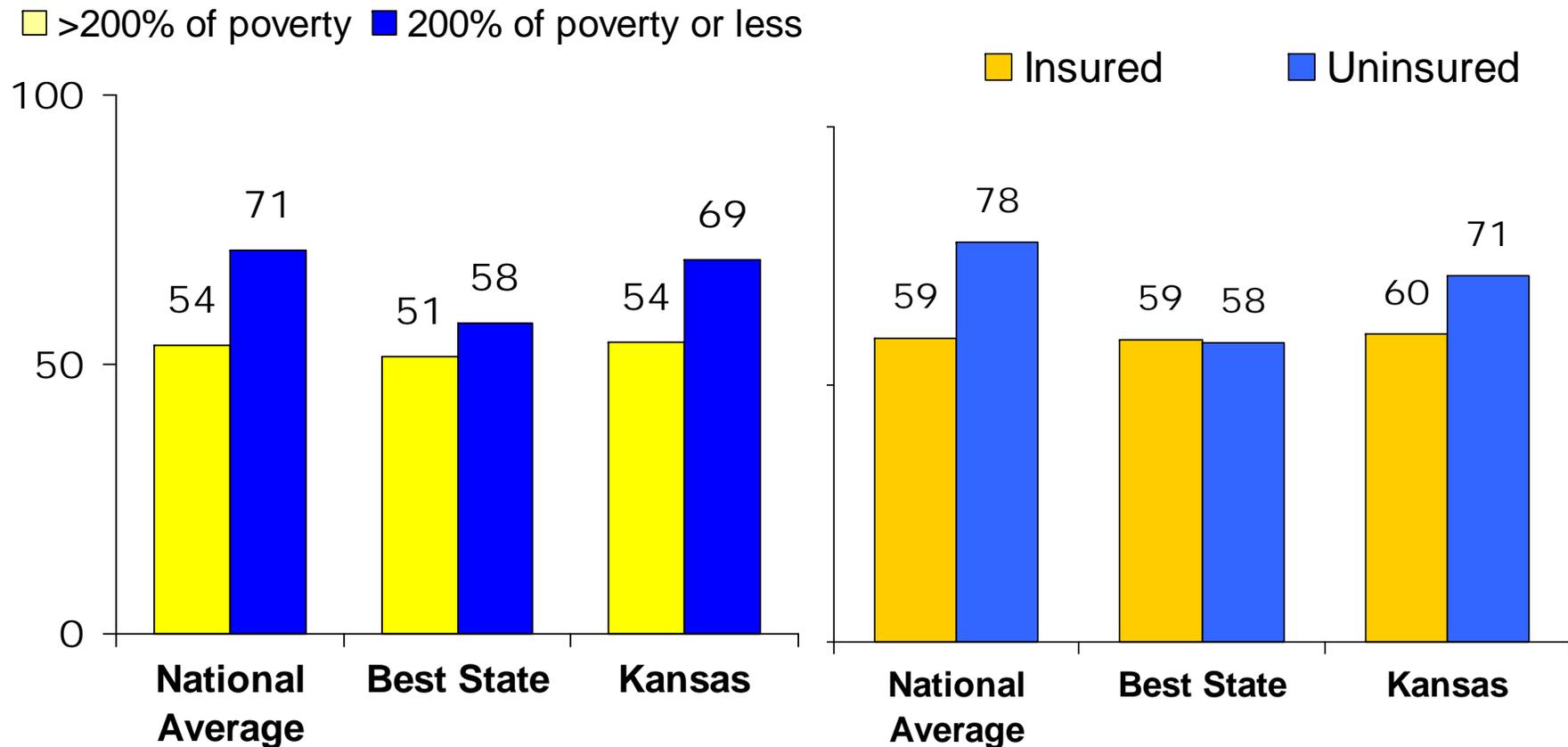
Percentage (of all deaths)

\* 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.

# Lack of Recommended Preventive Care

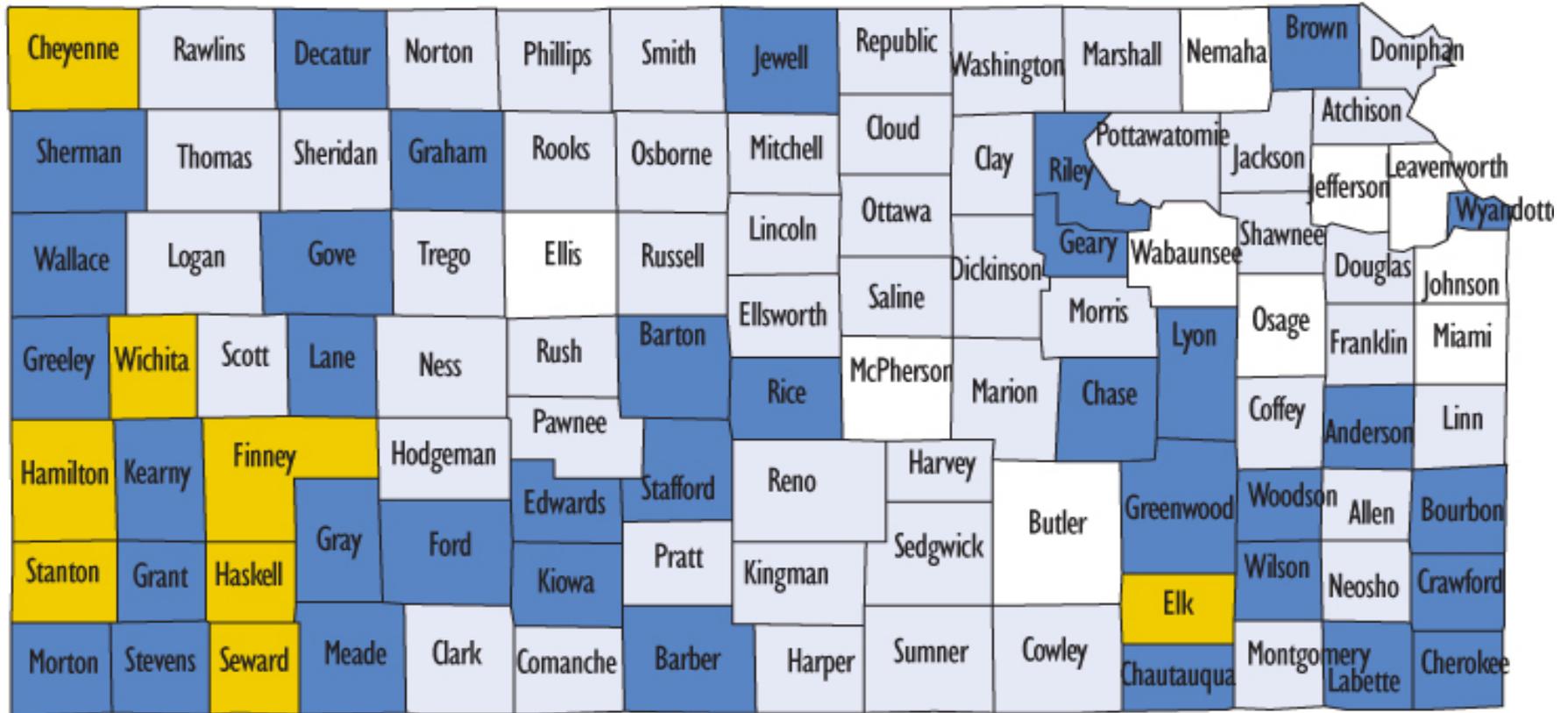
Percent of adults age 50+ who did NOT receive recommended preventive care  
By income By insurance



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

# Uninsured Rates in Kansas by County

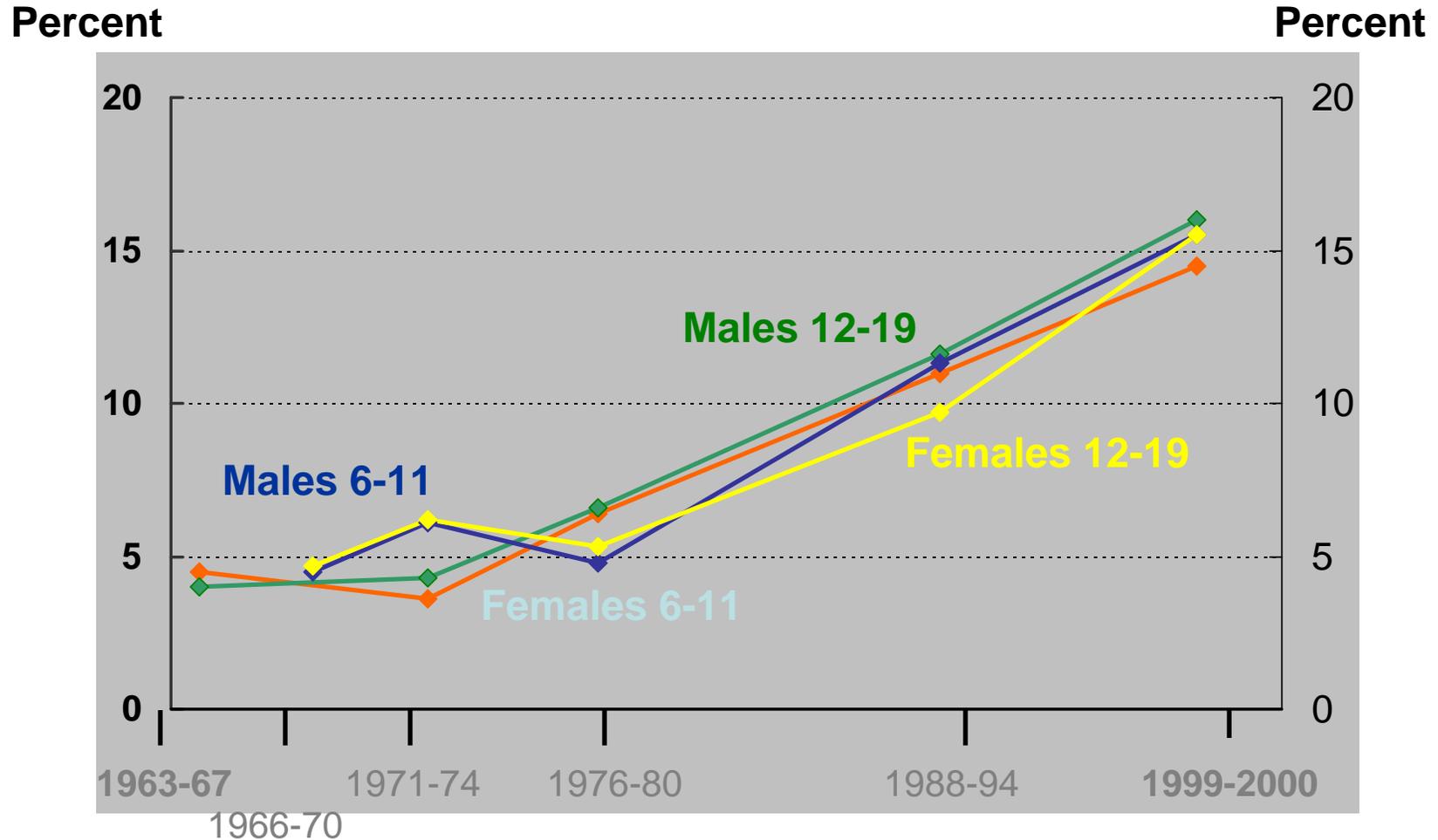


Percent uninsured:  6.5% to 10.0%  10.1% to 13.1%  13.2% to 17.9%  18.0% to 19.8%

Source: U.S. Census Bureau, Small Area Health Insurance Estimates (SAHIE) for 2000.

Kansas Health Institute. (2008). *Health Insurance and the Uninsured in Kansas*.

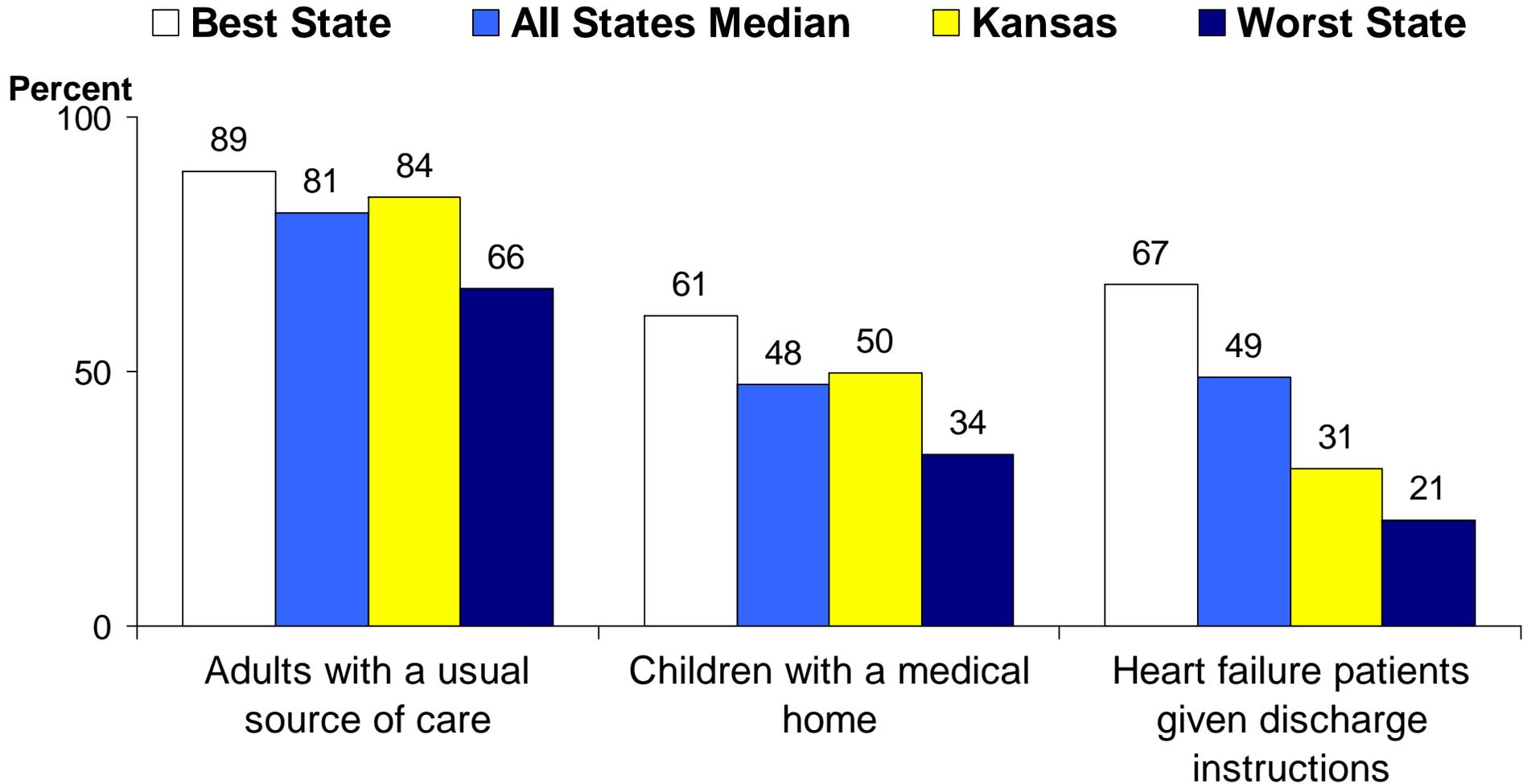
# U.S. Trends for Overweight Children and Adolescents



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.

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

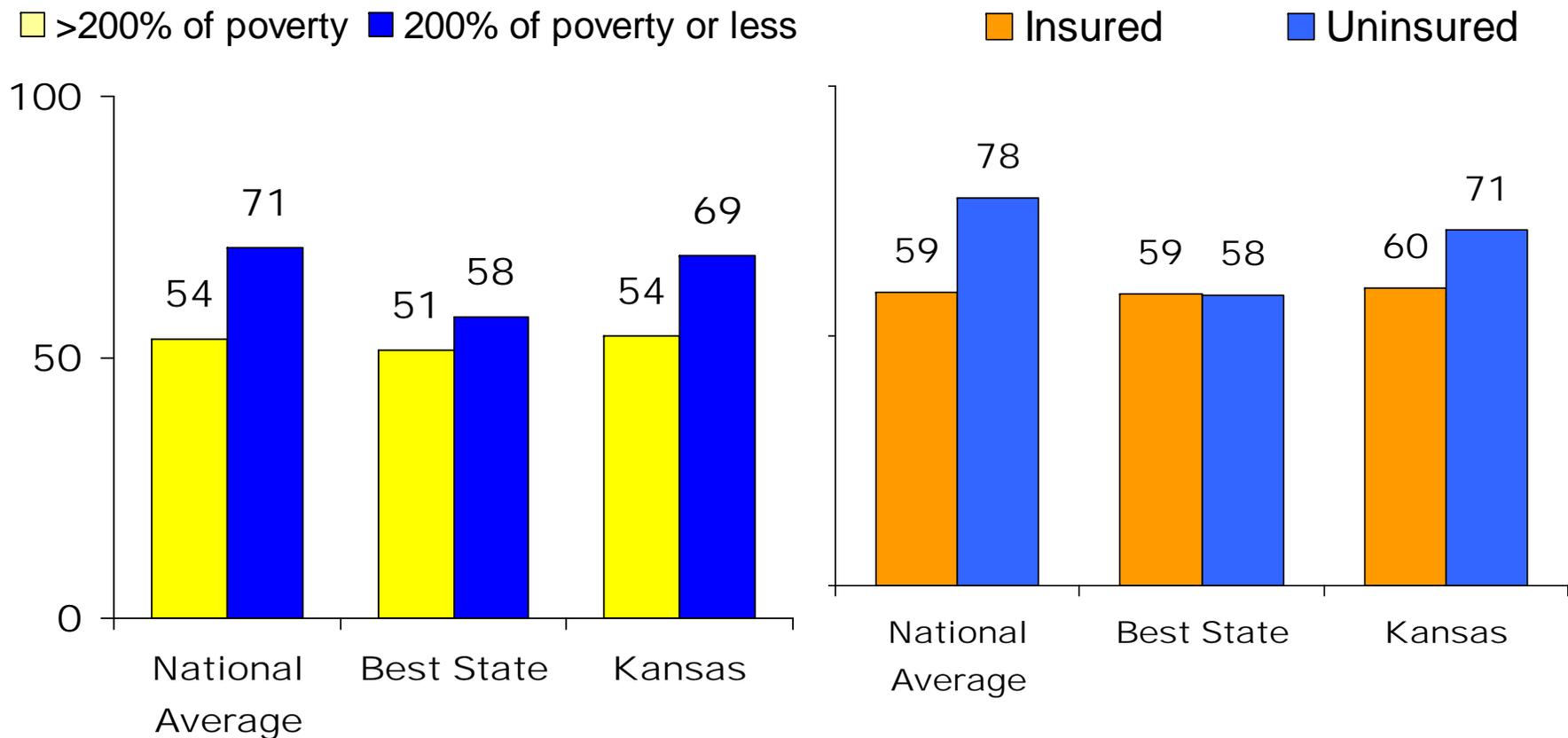
## EQUITY

# 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



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



# Health Reform Recommendations

Submitted by the KHPA Board to the Governor  
and Legislature on November 1, 2007



# Advisory Councils

- **Make-up:**
  - Health Care Consumers
  - Health Care Purchasers (e.g., Insurers, Businesses)
  - Health Care Providers
- **Purpose:** Assist the KHPA Board and Steering Committee (Board and legislators) with the development of health reform
- **Processes:**
  - Organized in March 2007; held monthly meetings
  - Delivered health reform recommendations to KHPA Board in Sept. 2007
  - Participating in community outreach



# Economic Analysis

- Funded by four Kansas health foundations
- Independent consulting firm, SchrammRaleigh Health Strategy
- Conducted actuarial analysis of multiple health insurance models (ranging from single payer to market-based reform)
- Insurance models reviewed and retooled with feedback from:
  - KHPA Board and Executive Staff
  - Kansas stakeholders and public



# Listening Tour

- **Purpose:** Gather public input on health reform in order to provide direction for the KHPA Board recommendations
- **Processes:**
  - Three week tour in August 2007
  - KHPA Board members and staff visited with 22 cities statewide (34 meetings)
  - Delivered summary comments to KHPA Board at Aug. and Oct. meetings
  - Publicized online “suggestion box” for public to provide suggestions and/or comments about health reform



# Informing the Public

- Online access to all **health reform reports and testimony** through the KHPA website (w/i 24 hours)
- **KHPA E-newsletter** for weekly updates on the legislative process and health reform
- **Public meetings:** KHPA Board, Listening Tour, Advisory Councils and Steering Committees
- **Presentations** to organizations and communities
- **“Community Toolbox Kit” for local communities** to present on the KHPA Board Health Reform recommendations
- **News alerts** available through new news-service at the Kansas Health Institute website ([www.khi.org](http://www.khi.org))



# Health Reform Priorities & Messaging

- **Promoting personal responsibility**
  - Responsible health behaviors
  - Informed purchase of health care services
  - Contributing to health insurance costs, based on ability to pay
- **Paying for prevention and promoting medical homes**
  - Focus on obesity, tobacco control, chronic disease management and incentives for primary care medical homes
- **Providing affordable health insurance**
  - Focus on small businesses, children, and the uninsured



# 21 Recommendations: System Reform and Better Health

<h2>Transforming Medical Care</h2>	<h2>Improving Public Health</h2>	<h2>Expanding Affordable Insurance</h2>
<ul style="list-style-type: none"> <li>•Transparency project: health care cost and quality</li> <li>•Health literacy</li> <li>•Medical home definition</li> <li>•Medicaid provider reimbursement</li> <li>•Community Health Record (HIE)</li> <li>•Form standardization</li> </ul>	<ul style="list-style-type: none"> <li>•Increase tobacco user fee</li> <li>•Statewide smoking ban</li> <li>•Partner with community organizations</li> <li>•Education Commissioner</li> <li>•Collect fitness data in schools</li> <li>•Promote healthy foods in schools</li> <li>•Increase physical fitness</li> <li>•Wellness for small businesses</li> <li>•Healthier food for state employees</li> <li>•Dental care for pregnant women</li> <li>•Tobacco cessation in Medicaid</li> <li>•Expand cancer screening</li> </ul>	<ul style="list-style-type: none"> <li>•Aggressive outreach and enrollment of eligible children (target population: 20,000)</li> <li>•Premium assistance for low income adults without children (target population: 39,000)</li> <li>•Small business initiatives (target population: 15,000 young adults and 12,000 employees of small businesses)</li> </ul> <p style="text-align: right;">20</p>

# Highlights from Health Reform Compromise

- Expand Medicaid for Pregnant Women from 150 to 200% FPL
- Mandatory offer for Section 125 plans (flexible spending accounts for premium only plans)
- Expand SCHIP from 200% to 250% FPL (assuming increase in **federal funding**)
- Increase funding for Safety Net Clinics
- Add funds to Wichita Graduate Medical Education

# Paying for Health Reform

- 21 recommendations “paid for” for five years:
  - **Increased tobacco user fee**
    - Fifty cent increase in cigarette tax, increases annually to reflect an assumption for inflation
    - Smokeless tobacco products user fee
    - Revenue dedicated to the “Health Reform Fund”
  - **Increased federal matching dollars**
- Cost containment - built into majority of proposals
  - Long term cost containment linked to improved health status
  - “Hidden tax” of uncompensated care

# What Happened?



**Some progress in first year, but need for multi-year multi-stakeholder strategy**

# Health Reform Report Card

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



# Summary of 2008 Legislative Action

- Nine of KHPA's original 21 health reform recommendations were passed by legislature
- Any items that were considered controversial were requested to be studied-only
- Final health reform bill (SB 81) left some unfunded mandates

[See Legislative Session at a Glance for summary of final bill](#)



# Preliminary FY 2009 Budget Proposals

- Caseload (November)
  - Tobacco Cessation for Pregnant Medicaid enrollees  
\$40,000 SGF      \$100,000 AF
  - Dental Care Pregnant Women  
\$524,000 SGF      \$1,310,000 AF
- Supplemental Requests
  - Employer Sponsored Insurance for HealthWave/SCHIP \$125,000 SGF      \$250,000 AF
  - Add Citizenship Paperwork Requirement for HealthWave/SCHIP \$280,000 SGF      \$560,000AF



# LCC STUDY LIST RECOMMENDED AUTHORSHIP

- KHPA
  - 13 Studies-----Medicaid, OIG Fraud Recovery Payments, Medicaid buy-ins, state Medicaid reform, Health Opportunity Accounts, Small Business Health Insurance, and Transparency
- KDHE—1 Study on Physical Fitness
- OIG—1 Study on Fraud/abuse Policies
- KID—2 Studies on HSAs, HDHPs, Section 125 Plans, and Wellness Benefits Incentives
- KDOA—1 Study on LTC Medicaid Reform
- Revenue—1 Study on Small Business Tax Credits
- Physician Workforce & Accreditation Task Force—1 Study on Health Manpower Issue

# What's Been Done for Health Reform

- Actuarial Analysis funded by Foundations
- Health Reform plan development
- Advocates partnering around reform
- KHPA Board and staff outreach to communities
- Media relations/partnering



# Major Barriers to Passing Health Reform

- **Energy:** Coal plant debate center stage
- **Economy:** Concern about state budget
- **Election year:** all Kansas legislative seats (House and Senate) up for re-election
  - Many legislators raised concern about raising taxes in an election year
  - Opposition to statewide smoking ban – local control at issue



## Next Steps

- KHPA Board vows to continue reform push – and begin transformation of Medicaid
- Continued outreach to communities, including a Community Dialogue tour in the Fall of 2008
- Continued work with advocates, press
- Better education of the legislature
- *Need for message development for different audiences – health reform difficult to understand*



## Enlist More Help: Outreach & Education

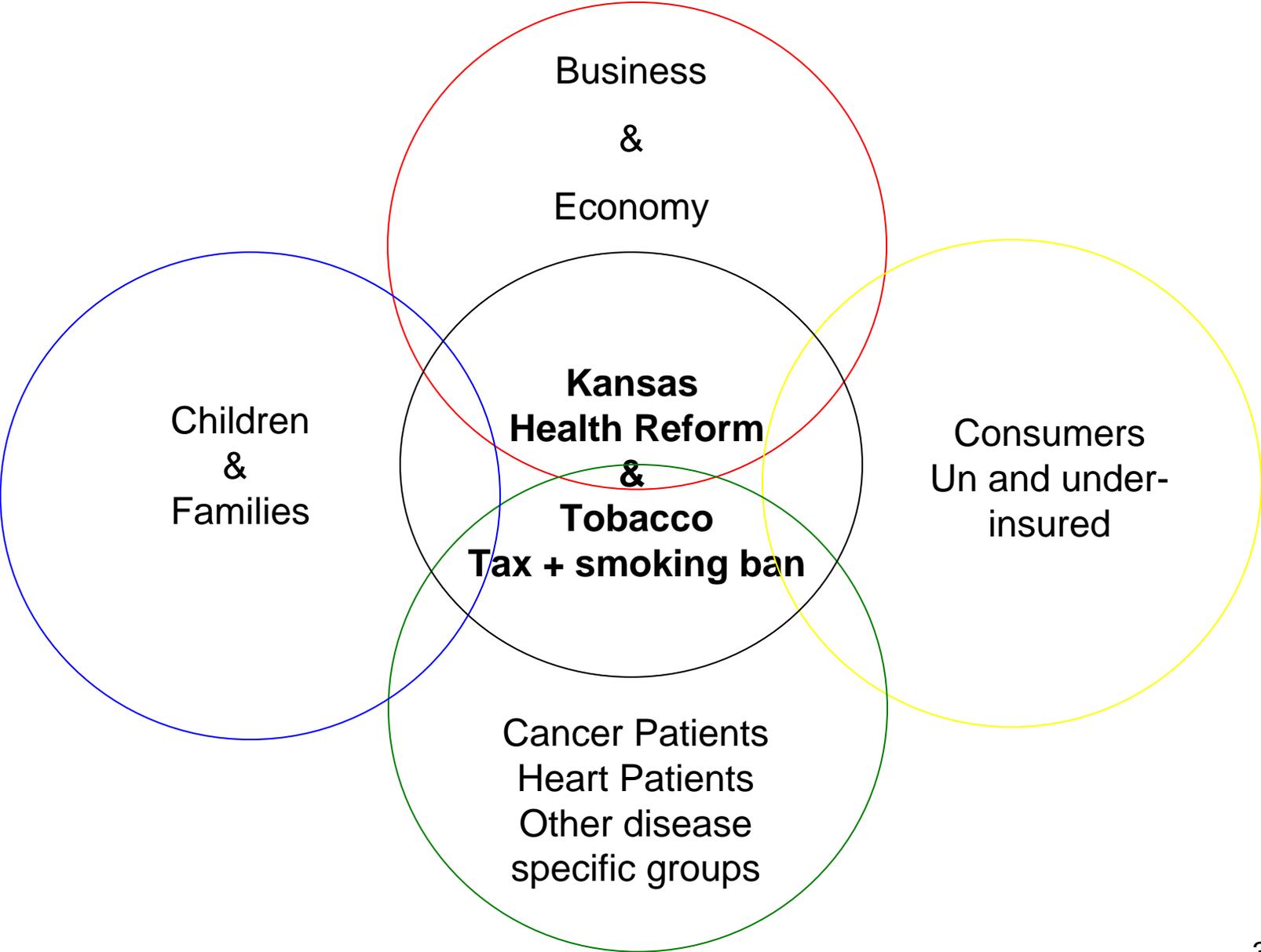
- **Health Reform Advisory Councils.** Meet in Aug to review proposed KHPA budget and health reform plans for 2009; additional meetings for remainder of 2008 will also be held.
- **Community Tours (30 to 40).** Scheduled for Sept/Oct 2008 to meet with community leaders across Kansas; public Townhall meetings will be held at each location.
- **Health 101 Tours.** To be scheduled for after election; meet specifically with legislators to educate on health reform efforts and KHPA



# Simpler Reform Plan

- **Push for Original Package with few changes:**
  - Increase Tobacco Products Assessment
  - Statewide Smoking Ban
  - Expand Medicaid Coverage for Parents/Caretakers
  - Tobacco Cessation for all Medicaid Recipients
  - Implement Statewide Community Health Record
  - Assist Small Businesses Purchase Affordable Health Insurance
  - Develop medical home model for Medicaid and State Employee Health Plan (payment reforms for 2010 session)

# Health Reform Messaging: Need to Better Target





# The Lynchpin of Kansas Health Reform **Tobacco:**

# The Cost; Human and Otherwise

- Smoking is the number one preventable cause of death in Kansas.
- Each year tobacco causes over 4,000 Kansas deaths, including 290 deaths attributable to second-hand smoke.
- Tobacco generates nearly \$930 million in health care costs annually.
- \$196 million of these health care costs occur within the Medicaid program alone.

# The Cost; Human and Otherwise (Cont.)

- 21% of high school students and 6% of middle school students currently smoke.
- 54,000 Kansas youth are projected to die from smoking.
- One in eight pregnant women residing in Kansas smoke, which results in poor birth outcomes and significant health care costs.
- Secondhand smoke results in 3,000 annual cancer deaths in the U.S. and 35,00 deaths from heart disease.

# The Tipping Point: Tobacco Legislation

- The Kansas Legislature voted down smoking/tobacco legislation in the last session.
- 83% of Kansans believe smoking is a serious health hazard.
- A statewide law in Kansas could result in 2,160 fewer heart attacks and \$21 million less in associated hospital charges.
- At least 35 states have imposed restrictions on smoking in public places.

# Smoking Bans in Other States

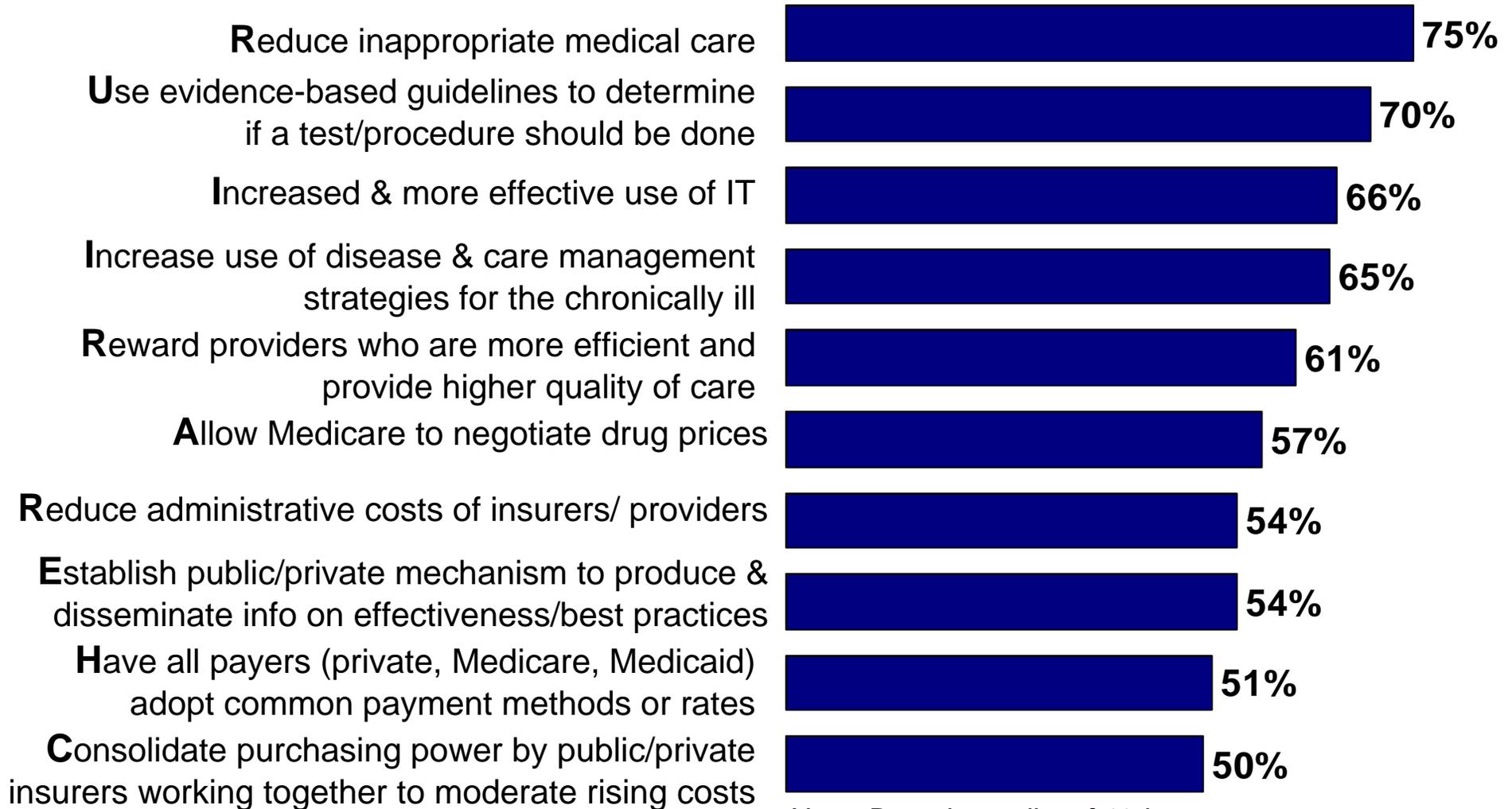
- **Requires most workplaces, including restaurants and bars, to be smoke-free.**
  - Maine, New Hampshire, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, Delaware, Maryland, Vermont, Ohio, Illinois, Minnesota, Washington, Oregon, California, Utah, Nevada, Colorado, Hawaii, Arizona, New Mexico, Puerto Rico, District of Columbia, Nebraska, Iowa
- **Requires most restaurants, bars and workplaces to be smoke-free but exempts restaurants and bars that don't admit people under age 18 or 21.**
  - Georgia, Tennessee, Arkansas
- **Requires all restaurants and most workplaces to be smoke-free, but exempts bars.**
  - Florida, Louisiana, North Dakota, South Dakota, Montana, Idaho



# OPERATIONALIZING 2008 ENACTED REFORM RECOMMENDATIONS

# Health Care Opinion Leaders: Views on Controlling Rising Health Care Costs

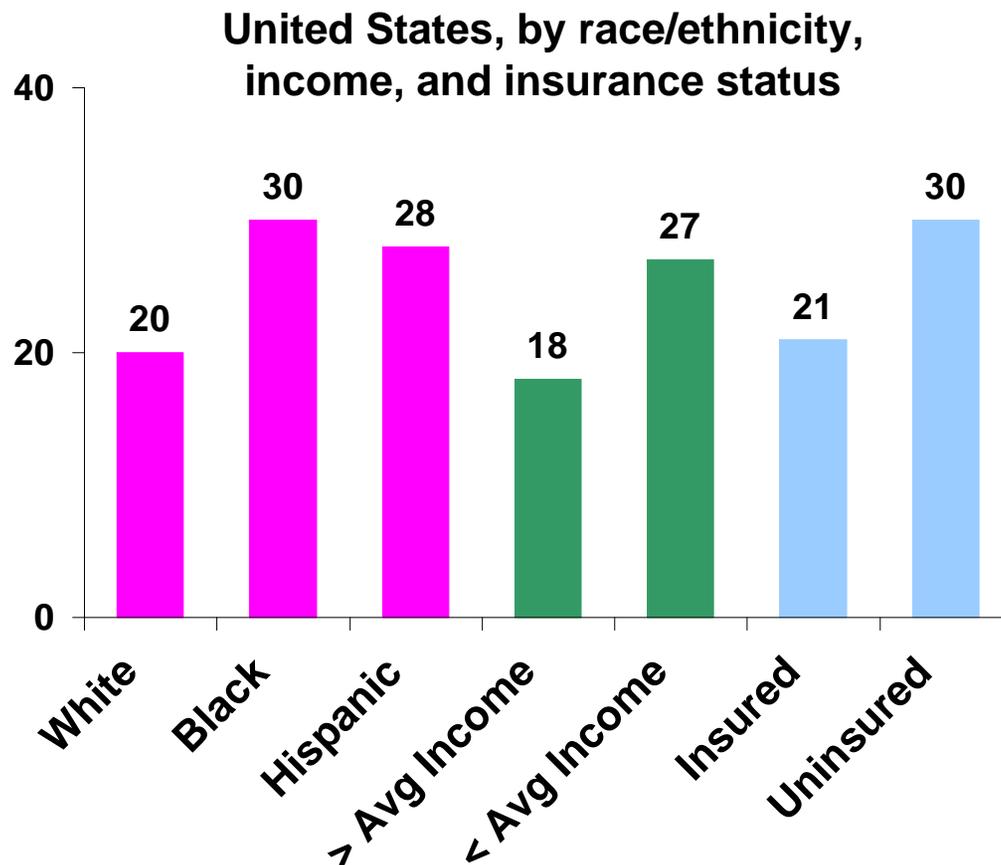
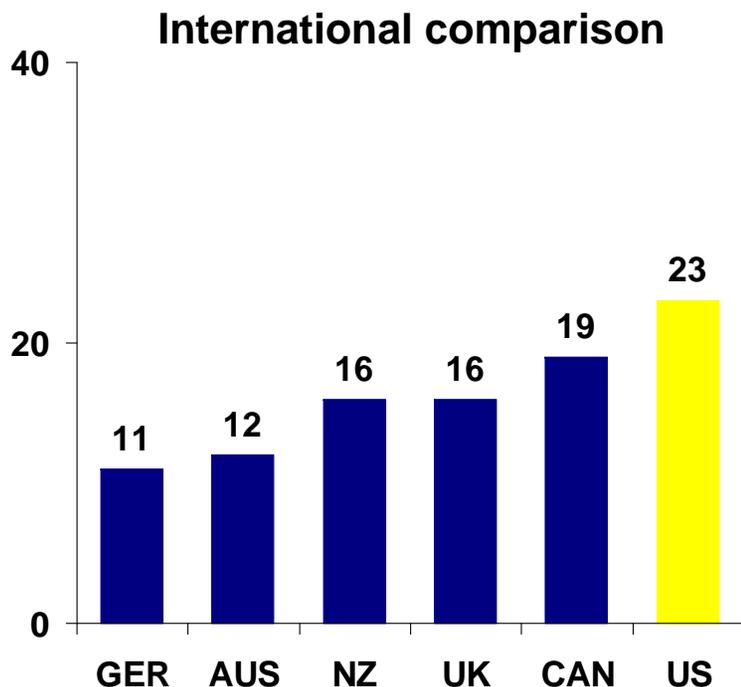
“How effective do you think each of these approaches would be to control rising costs and improve the quality of care?” Percent saying “extremely/very effective”



Note: Based on a list of 19 issues. 5

## Test Results or Medical Record Not Available at Time of Appointment, Among Sicker Adults, 2005

Percent reporting test results/records not available at time of appointment in past two years



GER=Germany; AUS=Australia; NZ=New Zealand; UK=United Kingdom; CAN=Canada; US=United States. Data: Analysis of 2005 Commonwealth Fund International Health Policy Survey of Sicker Adults; Schoen et al. 2005a.

# Getting Value for Money: Health System Transformation

- Transparency; public information on clinical quality, patient-centered care, and efficiency by provider; insurance premiums, medical outlays, and provider payment rates
- Payment systems that reward quality and efficiency; transition to population and care episode payment system
- Patient-centered medical home; Integrated delivery systems and accountable physician group practices
- Adoption of health information technology; creation of state-based health insurance exchange
- National Institute of Clinical Excellence; invest in comparative cost-effectiveness research; evidence-based decision-making
- Investment in high performance primary care workforce
- Health services research and technical assistance to spread best practices
- Public-private collaboration; national aims; uniform policies; simplification; purchasing power



# 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

# H. Sub SB 81

“Medical home means a health care delivery model in which a patient establishes an ongoing relationship with a physician or other personal care provider in a physician-directed team, to provide comprehensive, accessible and continuous evidence-based primary and preventive care, and to coordinate the patient’s health care needs across the health care system in order to improve quality and health outcomes in a cost effective manner.”

# How Will I Know One When I See One?

- Commitment to care for the whole person
- Demonstrated use of tools and systems including registries and eventually EHR
- New NCQA medical home recognition program (PPC)
- Patient satisfaction and health outcomes



# Medical Home-Key Elements

- Team approach to care
- Registries for the top few diagnoses
- Active care coordination
- Prospective data collection
- Partnership with community resources
- Advanced patient education and self management support



# PCMH-PPC Proposed Content and Scoring

<b>Standard 1: Access and Communication</b> A. Has written standards for patient access and patient communication** B. Uses data to show it meets its standards for patient access and communication**	Pts 4  <u>5</u> 9	<b>Standard 5: Electronic Prescribing</b> <b>A. Uses electronic system to write prescriptions</b> <b>B. Has electronic prescription writer with safety checks</b> <b>C. Has electronic prescription writer with cost checksa</b>	Pts 3 3  <u>2</u> 8
<b>Standard 2: Patient Tracking and Registry Functions</b> <b>A. Uses data system for basic patient information (mostly non-clinical data)</b> <b>B. Has clinical data system with clinical data in searchable data fields</b> <b>C. Uses the clinical data system</b> <b>D. Uses paper or electronic-based charting tools to organize clinical information**</b> E. Uses data to identify important diagnoses and conditions in practice** <b>F. Generates lists of patients and reminds patients and clinicians of services needed (population management)</b>	2 3 3 6 4 <u>3</u> 21	<b>Standard 6: Test Tracking</b> A. Tracks tests and identifies abnormal results systematically** <b>B. Uses electronic systems to order and retrieve tests and flag duplicate tests</b>  <b>Standard 7: Referral Tracking</b> <b>A. Tracks referrals using paper-based or electronic system**</b>	7 <u>6</u> 13  <u>4</u> 4
<b>Standard 3: Care Management</b> A. Adopts and implements evidence-based guidelines for three conditions ** <b>B. Generates reminders about preventive services for clinicians</b> <b>C. Uses non-physician staff to manage patient care</b> <b>D. Conducts care management, including care plans, assessing progress, addressing barriers</b> <b>E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities</b>	3 4 3 5 <u>5</u> 20	<b>Standard 8: Performance Reporting and Improvement</b> A. Measures clinical and/or service performance by physician or across the practice** <b>B. Survey of patients' care experience</b> C. Reports performance across the practice or by physician ** <b>D. Sets goals and takes action to improve performance</b> E. Produces reports using standardized measures <b>F. Transmits reports with standardized measures electronically to external entities</b>	3 3 3 3 2 <u>1</u> 15
<b>Standard 4: Patient Self-Management Support</b> <b>A. Assesses language preference and other communication barriers</b> <b>B. Actively supports patient self-management**</b>	2 <u>4</u> 6	<b>Standard 9: Advanced Electronic Communications</b> <b>A. Availability of Interactive Website</b> <b>B. Electronic Patient Identification</b> <b>C. Electronic Care Management Support</b>	1 2 <u>1</u> 4
<b>** Priority Elements</b>			10

# KHPA & Medical Home

- Process to define a Kansas medical home passed as part of health reform
- Kansas selected to participate in State Quality Institute (Joint venture through Commonwealth/Academy Health) – goal to operationalize and implement medical home
- Stakeholder process to begin this summer
  - Interested organizations: Kansas Academy of Family Physicians (KAFFP), Kansas Medical Society (KMS), Kansas College of Physicians (KACP), Kansas Hospital Association (KHA), Kansas Association for the Medically Underserved (KAMU), Children’s Mercy Family Health Partners (FHP).

# 2008 State Quality Institute

- Nine states selected to participate
- Goals
  - Offer customized support to state for quality improvement
  - Identify appropriate tools and expertise to assist state policymakers
  - Allow states to network and discuss experiences, challenges and best practices
  - Improve quality of health care!





# Most Frequently Chosen Indicators

Indicator	States
Percent of Adult Diabetics Who Received Recommended Preventive Care	CO, MA, MN, NM, OH, VT
Percent of Children with a Medical Home	CO, KS, OR, WA
Percent of Adults Age 50 and Over who Received Recommended Screening and Preventive Care	NM, OH, VT



# Quality Institute Timeline

- Spring 2008 – Spring 2009
  - April 2008 – June 2008: Site visits
  - June 20: Draft Action Plan Due
  - June 25-27: Kick-Off Meeting in Chicago
  - July 31: Action Plan Due
  - Summer 2008 – Spring 2009: Technical Assistance, Cyber Seminars, Project Bulletin Board
  - Spring 2009: Final meeting





# KANSAS MEDICAL HOME WORK PLAN

- Eighty-five percent of children in Kansas will have a medical home
- Avoidable hospitalization for pediatric asthma in Kansas will be reduced to no more than 82 per 100,000 for children aged 0 to 17 years

# Available “Technical Assistance”

On an as-needed basis, the AH team can provide:

- Background research
- On-site consultation visits
- Consultation with expert faculty
- Project website and bulletin board
- 4 Cyber Seminars
- TA is at no cost to states





# **Community Health Record Pilot Project**

**Development & Utilization of HIT and  
HIE in Kansas**



# Kansas Medicaid Community Health Record (CHR)

- **Location:** Sedgwick County, KS
- **Pilot Population:** Medicaid Managed Care
- **Purpose:** To improve the quality, safety, and cost-effectiveness of care
- **Timeline:**
  - Launched in February of 2006
  - Currently implemented in 31 sites (Target = 40)
  - Submitted a budget enhancement request of \$50,000 SGF for FY 2009 to expand program to 20 additional sites in Sedgwick County
  - Statewide expansion included in KHPA Board health reform recommendations for 2008 legislative session



# Kansas Medicaid CHR Pilot (Con't)

- **Utilization:** Medicaid providers accessed 7,487 records for 4,620 unique patients in 2007
- **Functions:**
  - Web-based tool via Cerner designed platform
  - Online provider access to over 8 years of aggregated claims data and health transactions regarding a patient's office visits, hospitalizations, medications, immunizations, and lead screening data
  - Real-time e-prescribing function alerts providers of contraindication to prescribed therapy, generic alternatives, preferred drug lists, formulary information and the ability to automatically route to the pharmacy

# Three Types Of Electronic Health Records



## ■ Provider Electronic Health/Medical Record (EHR or EMR)

- ◇ Legal medical record owned and used by providers to manage their own patient population
- ◇ Used across multiple venues of care within an enterprise for multiple conditions

## ■ Community Health Record (CHR)

- ◇ “Community owned” record that serves a “politically viable” geography, region, or health system network
- ◇ Crosses traditional provider system’s boundaries
- ◇ Derives summary information from multiple sources
- ◇ Ties into a national health infrastructure
- ◇ Enables bio-health, public health, outcomes management

## ■ Personal Health Record (PHR)

- ◇ Personally-managed health data
- ◇ Populated with data from CHRs and EMRs
- ◇ Wellness programs/condition mgmt.

# Key Features & Benefits

- Provides a quick summary of key activity information
- Web-based, easy to deploy and easy to learn
- Patient-centered record of aggregated health data
- Enables both aggregated and “shared only” views of the information
- Contains extendable services, e.g. in-box, eRx, etc.
- Stepping-stone towards a full EMR

# Data Included

- Patient Demographics
- Visit History (Diagnosis and Procedures)
- Allergies
- Medications
- Immunizations
- Results
- Benefit Information (i.e. Health Plan, Formulary)

# Potential Community Impact

- **Better, coordinated care and oversight**
- **Reduced waste:**
  - ◇ Reduced inpatient admissions due to incomplete data
  - ◇ Reduced repeat outpatient visits due to incomplete data
  - ◇ Lower ED expenditures
  - ◇ Decrease in repeat or unnecessary laboratory tests
  - ◇ Decrease in repeat or unnecessary radiology procedures
- **Patient Safety and Cost Savings Due to e-Prescribing**
  - ◇ ADE savings
  - ◇ Formulary-driven savings
  - ◇ Generic vs Brand savings
  - ◇ Problem driven medication ordering
  - ◇ Reduction in medication waste – redundant orders
- **Fraud and Abuse Detection**
- **Provider Efficiency**
  - ◇ Reduced time on phone with labs getting results
  - ◇ Reduced time on phone with pharmacy clarifying prescriptions or obtaining prior authorization
  - ◇ Reduced time on phone with other providers
  - ◇ Increased throughput (due to time savings)

# Sedgwick County Pilot Timeline

## ■ Phase I – February, 2006

- ◇ Community Health Record (20 sites/ 400 Providers)  
*FirstGuard Medicaid Members*  
*Demographics, Claimed Visits, Dispensed Medications, Immunizations*  
*12 months of historical claims data; continue data uploads through 2006*
- ◇ Documentation  
*Allergies*  
*Kan Be Healthy*

## ■ Phase II – May, 2006

- ◇ HealthConnect Members
- ◇ ePrescribing roll-out (SureScripts Connection – June, 2006)
- ◇ Lead Screening Results

## ■ Phase III – January, 2007

- ◇ Transitioned MCO's  
*UniCare & Children's Mercy Family Health Partners*
- ◇ New Functionality  
*Change Password Capability, Add Patient*  
*EPSDT Enhancements, etc.*

## ■ Phase IV - March, 2008

- ◇ Pilot Expansion - 20 Additional Sites Across Sedgwick County

# CHR Site Breakdown

## ■ Total Trained CHR Sites = 31 (Target = 40)

- ◇ Mental Health Facilities
- ◇ Emergency Departments
- ◇ Family Care Centers
- ◇ Pediatric Care Centers
- ◇ Home Health Agencies
- ◇ Safety Net Clinics
- ◇ Federally Qualified Health Centers (FQHC)
- ◇ Specialty Clinics

# Evidence of Success

## ■ Physician Satisfaction Survey (April 2006)

- ◇ 86% of the users surveyed agreed/strongly agreed the CHR increases their access to relevant information outside of their four walls
- ◇ 78% of respondents agreed that the CHR assisted them in providing improved care
- ◇ 97% of the users surveyed would recommend the CHR to their colleagues

## ■ Anecdotal examples (Collected Weekly)

- ◇ “I looked up a patients Rx history and stopped the process of prescribing further pain med’s because I was able to see the patient was already on Lortab, which I was unaware of. “ – Hunter Health
- ◇ “GraceMed is now able to look up patient medication information to get a more accurate list of what the patients are taking. In the past, the patients did not or could not provide a complete list, but with the Community Health Record, we now have the information we need readily available.” – GraceMed Topeka

## ■ KHPA Evaluation Study, Televised Press Release, & Site Visits

- ◇ Provided data for Dr. Tom Wilson & initiated site visits to develop a follow-up user satisfaction survey
- ◇ Conducted numerous successful site visits and reference calls for other states
- ◇ Successful press release event showcasing physician user perspective

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# Key Project Statistics

- **600 Trained Users**
- **31 Unique Sites**
- **EPSDT Forms Completed – 1,420**
- **Patient Searches Executed– 25,000**
- **ePrescribing Scripts – 700**

# CareEntrust: Kansas City Health Exchange

- **Location and Participants:** Non-profit organization comprised of 24 of Kansas City's leading employers and health care organizations including Kansas State Employee Health Plan (SEHP)
- **Purpose:** To develop and manage the CHR as a means to improving patient safety and avoiding costly and wasteful health care practices
- **Timeline:** In May, 2008 the SEHP CHR was launched for Wyandotte, Leavenworth, and Johnson Counties

# Kansas City Health Exchange (Cont')

- **Community Health Record Details:**
  - Consists of a central data repository that stores comprehensive, person-centric health data for provider access
  - Aggregates information from health plans, pharmacy benefit managers, laboratories, and immunization registry data
- **Target Population:** SEHP has over 12,000 covered lives in the Kansas City MSA



# Transforming Medicaid

- Brief overview of Medicaid
- Kansas Medicaid in context
- The Medicaid Transformation Process



# What is Medicaid?

- In a twelve-month period, Medicaid and SCHIP will pay for health services or provide health insurance coverage for about 400,000 Kansans

...but this is more a statement of what Medicaid *does* than what it *is*.



# A Working Definition of Medicaid

- Medicaid is an optional source of matching funds for states wishing to purchase healthcare for selected populations
  - Federal share varies from 50%-90%
  - Opting out is hard to do...
  - It is a payment source, but is thought of as an insurance product
  - Run by states, governed jointly
  - Strings are attached: lot's of them



# Federal Timeline for the Medicaid Program

- Preceded in 1960 by the Kerr-Mills program for “medically indigent seniors”
  - Also an optional Federal matching program
  - Only 32 states participated
- Medicaid created in 1965 as Title XIX of the Social Security Act
  - Overseen at Federal level by the Social Rehabilitation Administration
- HCFA created in 1975
  - Renamed the Center for Medicare and Medicaid Services (CMS) in 2001
- SCHIP created in 1997



# What are the Federal rules?

- Minimum eligibility requirements
  - SSI and TAF recipients
  - Children living in poverty
- Minimum requirements for benefits
  - Comprehensive package
  - All medically necessary care for children
  - Little or no cost to most beneficiaries
- Rules of equity
  - “statewideness”
  - “freedom of choice”



# What flexibility do States have?

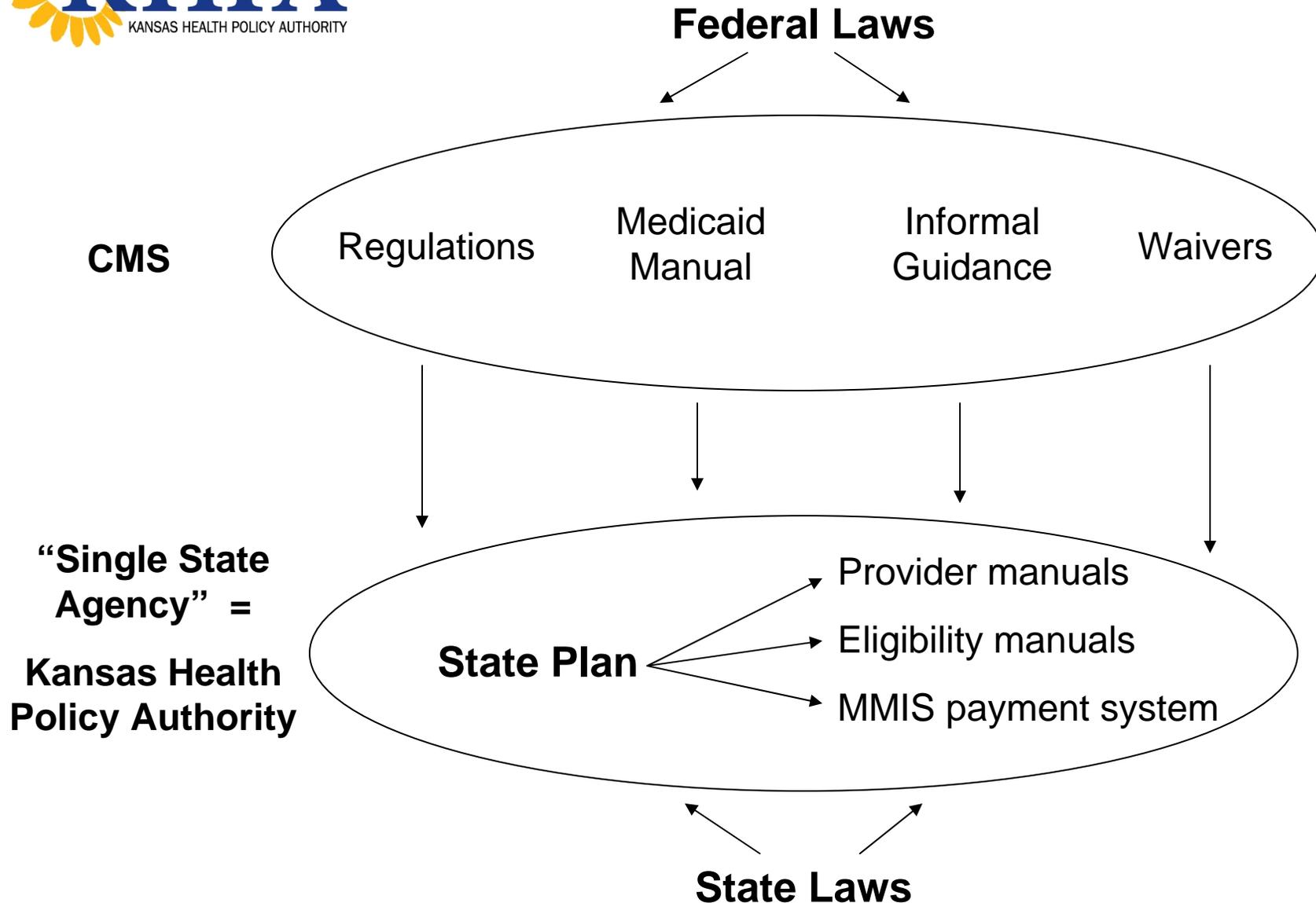
- Optional eligibility requirements
  - Parents above 30% of poverty
  - Children above poverty line (roughly)
  - Individuals with specific health care needs
- Optional benefits
  - Dental services for adults
- Limited or alternative benefits
  - Deficit Reduction Act of 2005
  - Some freedom to limit benefits or offer cash to consumers to buy health care on their own
- Service delivery mechanisms
  - Managed care
  - Consumer-driven approach (limited)



# What is Medicaid Policy?



# Defining Medicaid Policy





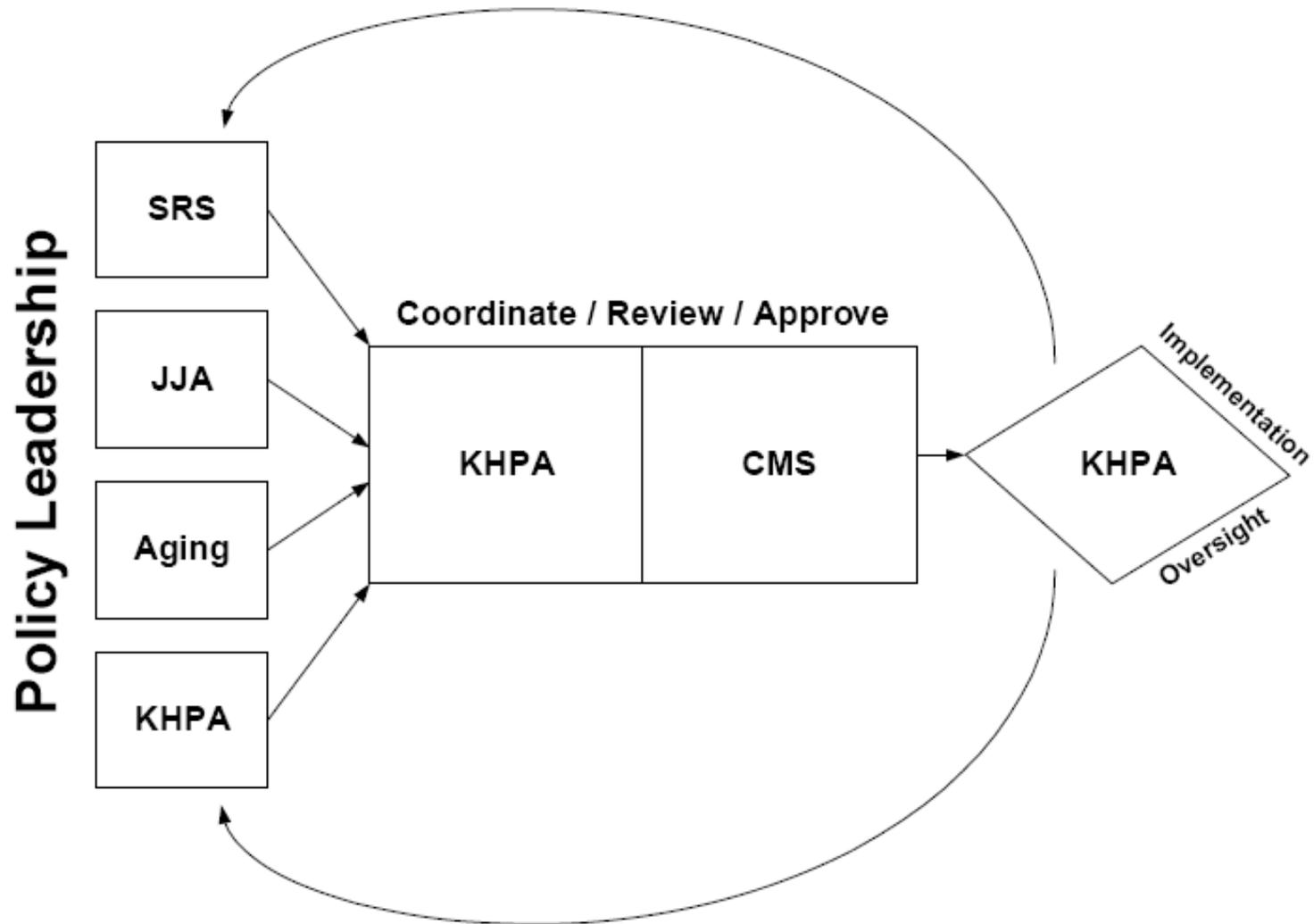
# How is Medicaid Policy made in Kansas?



# Agency Roles

- KHPA
  - Coordinate health policy
  - Single state agency
  - Physical health services
  - SCHIP (Title XXI)
  - MediKan
- SRS
  - Mental health services
  - Disability-related waivers
- Aging
  - Long-term care services and waiver

# Policy Development





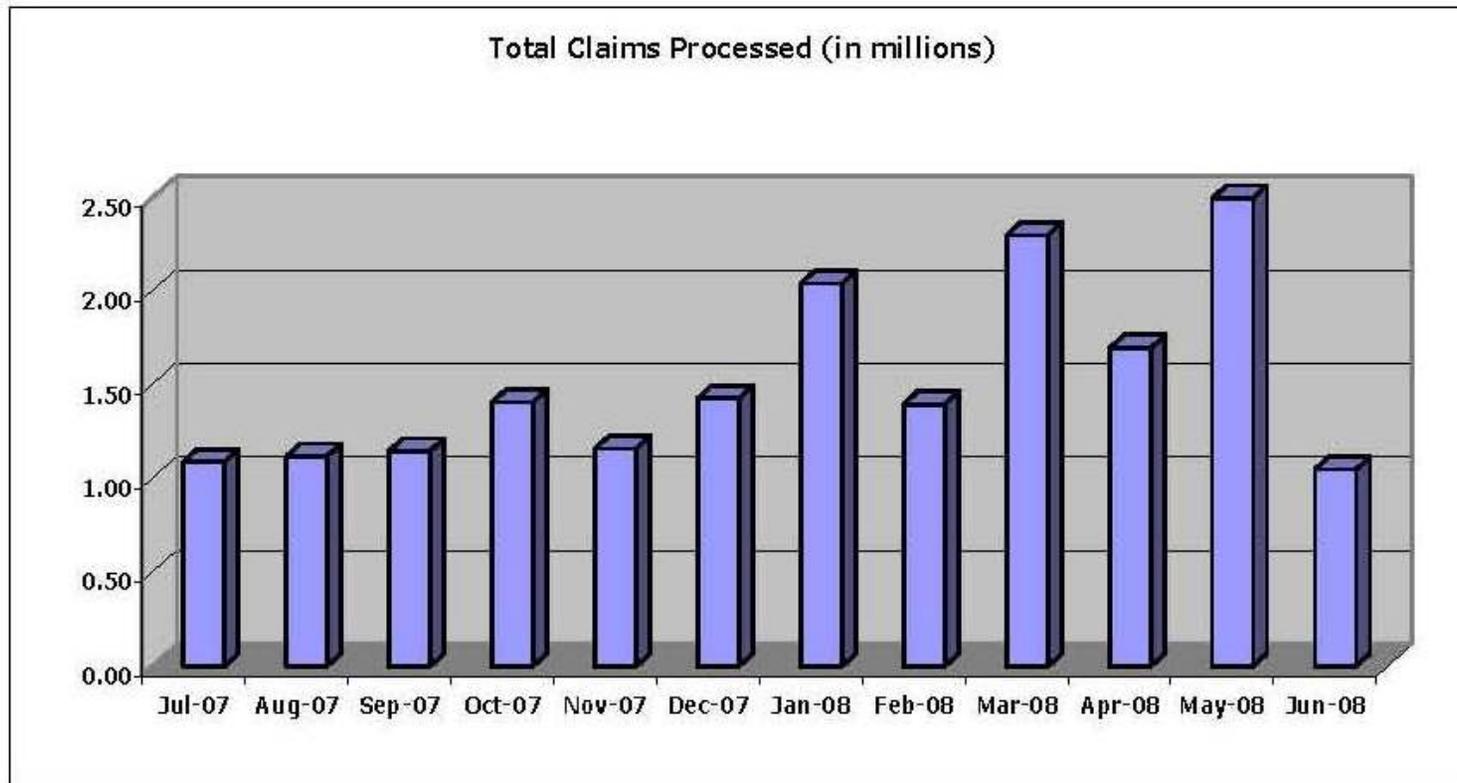
# What does Medicaid buy?



# Medicaid as Insurer

- Medicaid is the 3rd largest provider of health benefits coverage in Kansas after Blue Cross/ Blue Shield and Medicare
- Single largest insurer of children
- Medicaid pays for 40% of births in Kansas

# Number of Medicaid payments exceeds 1 million each month



# Medicaid claims paid average about \$180 million per month





# Medicaid -- Customers

- Eligibility by reason of income level only
- Eligibility by reason of income and disability or medical condition
- Eligibility by reason of income and age



# Customers – Populations

## Mandatory

- SSI Aged/Blind/Disabled
- Medically Needy
- TAF Caretakers
- Poverty level  
Infants/Children/Pregnant  
Women
- Children in Foster  
Care/JJA
- Low-income Medicare  
enrollees

## Optional

- Home and Community  
Based Service Waivers
- Breast and Cervical  
Cancer
- Working Healthy
- *Non-Medicaid, state-  
only funding:*
  - MediKan*
  - AIDS Drug  
recipients  
(ADAP)*



# Products – Medicaid Services

## **Mandatory Services**

- Phys. services
- Lab & X-rays
- Inpatient & Outpatient Hospital
- EPSDT
- Family Planning
- FQHC Services
- RHC Services
- Transportation
- Nursing Facility Care
- Home Health Care

## **Optional Services**

- Prescription Drugs
- Dental Services
- Case Management
- Diagnostic, rehab, preventative services
- ICF/MR
- Private duty nursing
- Personal Care
- Graduate Medical Education (GME)
- Durable Med. Equip.



# Focus- Graduate Medical Education (GME)

- Medicaid provides an added percentage to inpatient care at state's training institutions to address GME costs
- Opportunities for program enhancements
- Need for program improvements
- KHPA will provide support to new working group

# Medicaid vs. Private Sector

## Medicaid

- **Low admin. costs**
- **Discounted rates**
- **Targets the poor**
- **Comprehensive: mental health, transportation, senior care, EPSDT for children**
- ***Uses both direct contracting and managed care***

## Private Sector

- **High admin. costs**
- **Market rates**
- **Poor cannot afford**
- **Coverage gaps: mental health, transportation, senior care, EPSDT for children**
- ***Uses both direct contracting and managed care***



# Is Medicaid a problem?



# Kansas Medicaid in Context



# Medicaid spending in Kansas

- \$2.2 billion in FY 2007 (all funds, all agencies)
- KHPA Medicaid programs accounted for \$1.2 billion
- Historic growth at 9.9% over previous decade
- Projected annual growth of 5.5% in FY 2009-2010



# Comparisons to Other States

- Overall spending per beneficiary is above average
- Coverage of children is typical
- Spending on aged and disabled is above average
- Coverage of low-income adults is very low



# Kansas Medicaid Successes

- The Working Healthy Program
- Enrollment rates and Clearinghouse
- Disproportionate Share Hospital Payment (DSH) methodology
- Presumptive Medical Disability
- Resolution of Federal audits and deferrals
- Rapid implementation of expanded managed care (HealthWave)



# Challenges in Medicaid and HealthWave

- Steadily – sometimes rapidly – rising costs
- Perceptions of inefficiency or fraud
- Strained relationships with providers
- Major gaps in coverage
- Historic focus on health care
  - *need to also focus on preventive care and wellness*
- Historic focus on paying bills
  - *need to also focus on effective purchasing of quality care*
- Historic focus on program survival
  - *need to also focus on market impact*
- Historic focus on responsive management
  - *need to also focus on assertive, data-driven program management*



# The Medicaid Transformation Process



# Transforming Medicaid: Policy Goals

- Cost-effectiveness
- Program integrity
- Coordinate program delivery
- Quality outcomes
- Health promotion and a medical home
- Gaps in coverage and access



# Transforming Medicaid: Data-Driven Decisions

- Examine overall expenditures and health care trends
- Rely on program experience
- Explain trends
- Apply policy goals
- Focus on unanswered questions



# Transforming Medicaid: Process Goals

- Transparent policy-making
  - Accountability
  - Disciplined approach
- Stakeholder involvement
  - Increased scrutiny of agency decisions
  - More input and better ideas
- Data-driven decision-making
- Continuity in policy discussions



# Transforming Medicaid: Comprehensive Program Reviews

- Began in 2007 with initial drafts
- Includes 14 overlapping program areas
- Four broad categories
  - Health care services and programs
  - Populations
  - Eligibility
  - Quality improvement
- To be repeated annually
- New topics for 2009 will include Medicaid operations and contract management



# Transforming Medicaid: Key Products

- Extended program reviews to be made available this fall
- Summaries for Board and Legislative consideration
- Program recommendations
  - Initiatives for FY 2009-2010 Budget
  - Administrative initiatives
  - Revenue-dependent initiatives
  - Areas for further study and policy development



# Transforming Medicaid Example: Medicaid Fee-for- Service Transportation Services

- Provided to ensure access to care
- Numerous, small-scale providers, some without other health care experience
- Administratively burdensome requirements
- Source of concern for program integrity
- \$10 million annual expenses continue to grow
  - in remaining population of aged and disabled
  - Fuel costs threaten profitability
- Limited resources for oversight and management



# Transforming Medicaid Example: Medicaid Fee-for- Service Transportation Services

- Recent program management activities
  - Limited provider enrollment
  - Increased documentation
  - Reduced program expenditures
  - Explored alternatives



# Transforming Medicaid Example: Medicaid Fee-for- Service Transportation Services

- Recommendation
  - Outsource management and direct contracting to a private transportation broker
  - Benefits of contracting with a broker include:
    - Increasing scrutiny
    - Right-sizing reimbursements
    - Generating modest net savings to the state



# Transforming Medicaid: Timeline

- February-August 2008
  - complete draft program reviews
  - develop draft staff recommendations
- July-August 2008
  - convene Medicaid Transformation Committee to review draft staff recommendations
- August-September 2008
  - Complete estimate of budget impact
  - KHPA Board consideration of draft recommendations
- Fall 2008
  - advance Board recommendations
  - publish full reviews
- February 2009
  - Repeat



# Transforming Medicaid: Concluding Observations

- Comprehensive approach is difficult, disruptive, and time-consuming
- Accelerates and improves policy-making
- Lays bare what we know
- Grounds KHPA recommendations in data and documented experience
- Presents an alternative to speculative Medicaid reforms based on anecdote or intuition
- Defines Transformation as a process, rather than a specific set of changes

*Coordinating health & health care  
for a thriving Kansas*



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