

Kansas Health Policy Authority

2007 Annual Legislative Report

presented to:
Kansas Legislature

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Executive Summary

The ultimate goal of the Kansas Health Policy Authority (KHPA) is to improve the health of Kansans. We stand ready to work with the Governor, Legislature, and stakeholders to focus on common sense health reform that works for Kansas.

It is critical to the success of this agency and the process of health care reform to enhance our current programs and initiatives, while creating new priorities for the future. This annual report looks back at the past year, but with an eye on the future.

This report:

- Displays the Kansas Health Policy Authority Board's approved vision principles and health indicators, which will be used to measure health outcomes;
- Outlines the agency's performance in its programs;
- Focuses on the upcoming challenges for the agency, both in terms of programmatic and operational priorities; and
- Provides information regarding each division and program within the Kansas Health Policy Authority purview.

We look forward to working with Governor Kathleen Sebelius, the Legislature, and our stakeholders in developing a plan that will ensure accessible health care for Kansans and embrace the vision statement the Kansas Health Policy Authority Board has defined as important to accomplishing its mission.

-Marcia Nielsen, Ph.D, MPH, Executive Director of the Kansas Health Policy Authority

Kansas Health Policy Authority

Vision Statement

KHPA: Coordinating health and health care for a *thriving* Kansas

Mission Statement

As expressed in KSA 2005 Supp. 75-7401, *et seq.*, the mission of Kansas Health Policy Authority (KHPA) is to develop and maintain a coordinated health policy agenda which combines the effective purchasing and administration of health care with health promotion oriented public health strategies. The powers, duties and functions of the Kansas Health Policy Authority are intended to be exercised to improve the health of the people of Kansas by increasing the quality, efficiency and effectiveness of health services and public health programs.

History of the Kansas Health Policy Authority

The Kansas Health Policy Authority (KHPA) is charged to develop a statewide health policy agenda including health care, health promotion components, and health indicators to include baseline and trend data on health care costs.

KHPA was established on July 1, 2005, as a new agency within the Executive Branch. For one year, the immediate predecessor to the Kansas Health Policy Authority was the Division of Health Policy and Finance (DHPF) within the Department of Administration. This division was also established on July 1, 2005, within the Department of Administration, and served as the single state Medicaid agency.

On July 1, 2006, DHPF was abolished, and the Authority assumed responsibility for Medicaid, State Children's Health Insurance Program (SCHIP), State Employees Health Benefits Program, and the State Employee Self Insurance Fund (Workers' Compensation). KHPA was also designated as the single state agency responsible to the federal government for all programs receiving federal Medicaid funds. However, certain long-term care services (e.g., nursing facilities, HCBS waivers, and mental health) continue to be managed on a day-to-day basis by the Kansas Department of Aging (KDOA) and the Kansas Department of Social and Rehabilitation Services (SRS).

The Authority is an independent state agency and is monitored and studied by the Joint Committee on Health Policy Oversight. The Kansas Health Policy Authority Board is comprised of nine voting members, who are appointed by the Governor and House and Senate leadership, and seven non-voting (ex-officio) members, who serve as a resource and support for the voting members. The appointed members will serve a four-year term, except the original members who were appointed to serve terms that vary for the first cycle.

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The Executive Director of the Authority has responsibility and statutory authority for the oversight of the Medicaid and SCHIP programs, the State Employees Health Benefits Program, State Employees Self Insurance Fund (Workers' Compensation), and the health care data responsibilities of the former Health Care Data Governing Board.

2006—Year in Review for Kansas Health Policy Authority

With its mission to develop and maintain a coordinated health policy agenda, the Kansas Health Policy Authority has been laying the structural groundwork for improving health policy in Kansas. Most importantly, programs previously under the purview of the Division of Health Policy and Finance were transferred to the Kansas Health Policy Authority on July 1, 2006. These programs include Medicaid, State Children’s Health Insurance Program, State Employees Health Benefits and State Employees Self Insurance Fund (Worker’s Compensation).

Among the many 2006 highlights, the Kansas Health Policy Authority Board approved six vision principles and an initial set of health indicators, as required by statute.

Vision Principles

The vision principles are the guiding framework of the Board and agency. Ranging from providing access to care to stewardship and education, these principles reflect the Board’s application of their statutory mission to the full range of health policies within their purview. The principles will provide direction to the agency in its ongoing work and in developing new initiatives and programmatic proposals.

Access to Care—Every Kansan should have access to patient-centered health care and public health services ensuring the right care, at the right place, and the right price. Health promotion and disease prevention should be integrated directly into these services.

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

Affordable and 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.

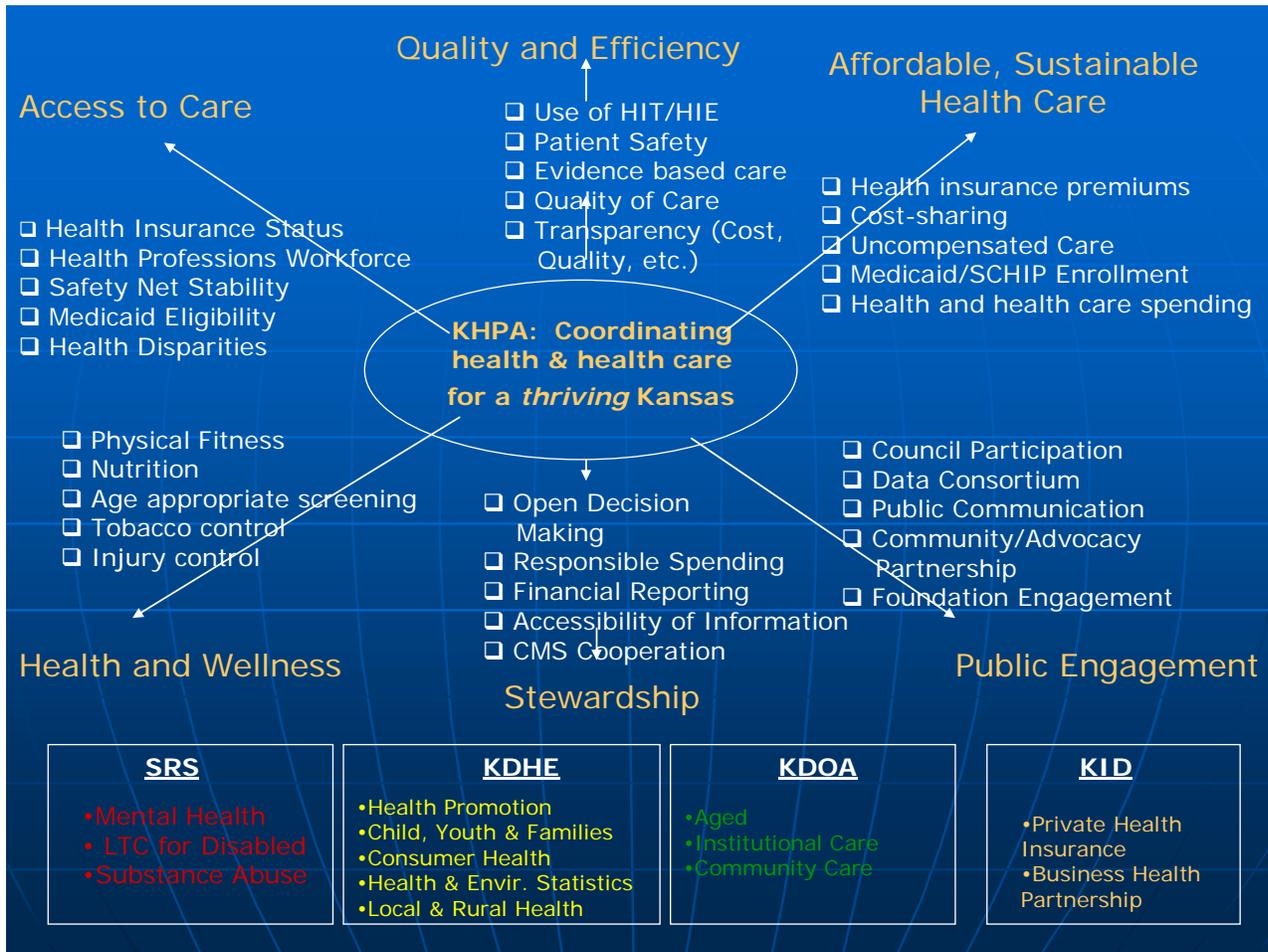
Promoting Health and Wellness—Kansans should pursue healthy lifestyles with a focus on wellness—to include physical activity, proper nutrition, and refraining from tobacco use—as well as a focus on the informed use of health services over their life course.

Stewardship—The Kansas Health Policy Authority will administer the resources entrusted to us by the citizens and the State of Kansas with the highest level of integrity, responsibility, and transparency.

Education and 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.

Health Indicators

As required by statute, the Kansas Health Policy Authority Board developed and approved an initial set of health indicators that correlate with each vision principle. These indicators will include baseline and trend data on health care, health outcomes, healthy behaviors, KHPA operational integrity, and health costs.



These health indicators have been reviewed and approved by the KHPA Board. The next step will be to identify the best way to quantify and measure these indicators to observe changes over time and track the impact of state health policy initiatives. Specific measures for each indicator will be developed and adopted by the Board in 2007.

Highlights of 2006

Other highlights during 2006 include strengthening operations of the agency, focusing on stakeholder relationships, and increasing communication with staff members, Legislature, Governor's Office, and stakeholders.

- ***Focused on budget and finance.*** Under new leadership of Dr. Marcia Nielsen as Executive Director, the Kansas Health Policy Authority has placed an increased focus on budget and finance areas of the agency.
 - KHPA developed and received Board approval for its first budget as a state agency.
 - KHPA is now engaged in monthly public reporting of budget performance and financial status, including key administrative and programmatic details.
 - KHPA was reorganized to reflect the increased focus on financial and budgetary responsibilities, including the hiring of the agency's first Chief Financial Officer, Scott Brunner, former Director of Kansas Medicaid and HealthWave programs.

- ***Increased communication.*** Communication and transparency are important parts of the process of advancing health policy in the state. The Kansas Health Policy Authority has worked to intensify its communication efforts with all stakeholders.
 - KHPA developed a new website, which is updated daily, www.khpa.ks.gov.
 - The agency instituted new ways to communicate with its staff, including the creation of a staff e-newsletter which is distributed weekly to staff members and established quarterly all-staff town hall meetings.
 - KHPA conducted five town hall meetings for stakeholders. These meetings were held in Hays, Kansas City, Wichita, Pittsburg, and Garden City, allowing area residents an opportunity to voice opinions regarding the future of Kansas health care. The agency will continue to hold town hall meetings throughout the state in 2007.
 - KHPA created an Interagency Deputy Secretaries Planning Group to better coordinate the health issues and policies facing all Kansans. The group meets monthly to discuss new initiatives, share ideas, and facilitate effective programmatic coordination.

- ***Developed and maintained relationships with stakeholders.*** Partnership is vital to successful programs and operations of the Kansas Health Policy Authority, and the agency has continued to develop its relationship with various stakeholders throughout Kansas.
 - KHPA collaborated with stakeholders to ensure the continued success of the Provider Assessment program.
 - The first two of an ongoing series of Disproportionate Share Hospital (DSH) policy planning meetings for hospitals were conducted to provide input that ensures funding is equitable and the program advances state health policy.
 - KHPA worked with other state agencies to develop and oversee implementation of a CMS audit, deferral and disallowance work plan to resolve outstanding issues, led by Dr. Barb Langner, Associate Professor in University of Kansas

School of Nursing with joint appointment in the School of Medicine, Department of Health Policy and Management.

- Working with stakeholders across the state, KHPA has continued to support collaborative efforts focused on health information technology and health information exchange initiatives. These initiatives are aimed at improving quality and efficiency in health and health care and ensuring protected health information is kept private and secure.
- ***Renewed emphasis on health and wellness.*** With data showing the importance of a healthy lifestyle, the Kansas Health Policy Authority has worked to emphasize the importance of health and wellness among Kansans.
 - L.J. Frederickson was hired as the State Employee Health Benefits and Plan Purchasing Director. This division is working to increase the promotion of health and wellness in the health benefits plan of state employees by developing a new health and productivity program built on an effective health risk assessment program which consists of incentive design and delivery, web interactive programming, education, coaching and capture of appropriate data for future planning. Emphasis is being placed on tobacco cessation, obesity and diabetes management.
 - Together, the Quality and Innovation and the State Employee Health Benefits divisions revamped the Pharmacy Benefits Manager contract, and through a competitive bidding process, signed a new agreement with Caremark that will improve quality of services and save both the State (\$3.6 million) and employees (\$3 million) a significant amount on prescriptions in the 2007 plan year.
 - KHPA's Quality and Innovation division's primary focus has been on health information technology (HIT) and exchange (HIE). The division is working with health care leaders across the state to develop recommendations for infrastructure that supports interoperable HIE in Kansas. The Quality and Innovation division continues to research and develop innovative programs that will improve the quality, safety and efficiency of health care, such as the CommunityRx Kansas program launched in January 2006. CommunityRx Kansas provided access to low-cost prescription drugs to 1,000 Kansans in 2006, and the program continues to grow today.
 - KHPA has explored additional health and wellness initiatives for Medicaid beneficiaries as outlined by the submitted FY 2008 budget, including reimbursement for dietary and nutrition counseling, integrating Medicaid immunization records with KDHE, and request for funding to study and implement health promotion programs for Medicaid beneficiaries.
- ***Strengthened Medicaid and HealthWave programs.*** As the single state Medicaid agency, the Kansas Health Policy Authority has strengthened its Medicaid and HealthWave programs to provide affordable and quality care to enrolled Kansans.
 - On July 1, 2006, KHPA became the single state Medicaid agency, bringing efficiency to the program and maximizing the state's purchasing power. KHPA is applying this leadership role in the multi-agency Medicaid program to increase transparency, improve cooperation, and streamline operations.

- KHPA signed contracts for Medicaid managed care services with two contractors, saving the state between \$10 to \$15 million annually and introducing choice and competition into this important and growing market.
 - KHPA submitted six Medicaid transformation grant proposals which will work to increase quality and efficiency of care. The proposal which aims to improve preventive health care for disabled Kansans who are enrolled in Medicaid was approved for grant funding.
 - KHPA conducted a systematic review of its Medicaid Information Technology Architecture (MITA) to identify opportunities for structural improvement in data management and operational structures. Future MITA reviews will focus on organization structure to more effectively coordinate health care purchasing.
- ***Maintained and improved existing programs.*** Throughout 2006, the Kansas Health Policy Authority has maintained and enhanced its existing programs.
 - **CommunityRx Kansas** is a statewide prescription assistance program launched in January 2006 to provide low-income, uninsured Kansans access to affordable prescription medication. CommunityRx Kansas is administered by two local Kansas firms, Right Choice Pharmacy and Prescription Network of Kansas, who together provide a statewide network of over 300 participating pharmacies. Since the program launched on January 4, 2006, over 1,000 Kansans have benefited from CommunityRx Kansas.
 - **The Community Health Record (CHR) Pilot** is a program testing the impact of a shared electronic health record on quality of care with Kansas Medicaid providers in Sedgwick County. Working with the Medicaid managed care plans (FirstGuard, then UniCare and Children’s Mercy Family Health Partners) and a technology vendor (Cerner Corporation), KHPA developed a network of physicians, clinics and hospitals that access a web-based shared electronic health record containing their Medicaid patient’s health information including demographics, diagnoses, office visits, procedures and prescriptions. In addition, the CHR includes a web-based e-prescribing tool. KHPA is working with an independent contractor (Trajectory Healthcare) to conduct an impartial evaluation of the impact of the CHR on quality of care. Initial feedback from providers has been positive. The pilot extends through June 30, 2007, with the evaluation ongoing. If the tool proves effective, the intent is to expand the CHR to the larger Medicaid population through a competitive bidding process.
 - **HealthyKids** is a pilot program that helps eligible state employees with their premium for children’s health insurance coverage in the State Employees Health Benefits Plan. The program covers children who meet the income guidelines for HealthWave but are ineligible because of federal guidelines that prohibit government employees from accessing. In HealthyKids, the state covers 90 percent of the premium (instead of the typical 45 percent average) and the employee pays only 10 percent for their eligible dependent children. To date,

2,500 children have received health care coverage through HealthyKids. Of those, approximately 550 were previously not enrolled in the state health plan.

- **Presumptive Medical Disability (PMD)** is a process that allows Medicaid agencies to make internal disability decisions and provide Medicaid coverage on a presumptive basis. The process is referred to as “presumptive,” because the determination is provided prior to the Social Security Administration (SSA) decision. This provides beneficiaries earlier access to full Medicaid coverage and permits the State to receive federal match prior to the final SSA disability decision. (MediKan, one of the programs for which this process is used, is not matched with federal funds.) It also provides applicants, who meet PMD criteria, full Medicaid coverage. PMD is used to provide disability determinations for people seeking disability-based Medicaid coverage and General Assistance (GA)/MediKan coverage. A two-tier evaluation for benefits is used. First the person is evaluated using Medicaid standards. Second, if these standards are not met, the person is evaluated under MediKan standards. Because MediKan and the GA cash program continue to be linked, persons meeting PMD criteria may also receive GA cash. New applicants who do not meet Medicaid or MediKan criteria are also not eligible for GA cash. Per legislative proviso (through March 1, 2007), existing GA/MediKan recipients continue to receive cash and MediKan benefits providing current GA/MediKan program requirements are met.
- **Presumptive Eligibility** for children is a valuable outreach tool that allows the State to provide coverage under Medicaid and SCHIP to children who appear to be eligible but are not yet enrolled. Presumptive Eligibility (PE) utilizes designated and trained Qualified Entities to determine if a child is presumptively eligible. KHPA has selected enrolled hospitals and safety net health clinics to act as Qualified Entities. The entity, which is in contact with the family at the time of a medical need, assists the family with the HealthWave application process and completes a PE determination for each child for whom assistance has been requested. The Qualified Entity benefits from participation in the program through a reduction in uncompensated care provided to under- and uninsured children accessing the program. KHPA is currently piloting PE in two hospitals and one safety net health clinic. This pilot project started in July 2006 with Children’s Mercy Hospital in Kansas City, Missouri. Via-Christi Regional Medical Center and GraceMed Health Clinic in Wichita were added to the pilot project in August 2006. The PE pilot is a method for KHPA to evaluate the validity of the PE determination tool and processes. In addition, the pilot is helping to provide additional data about take up rates for the program including additional cost and enrollment estimates. Outcomes from the pilot project are still being measured along with details for a phased-in implementation plan for expanding the program to other hospitals and clinics within the State.
- **Enhanced Care Management** is a pilot chronic management program in Sedgwick County. The voluntary program targets Medicaid beneficiaries with chronic disease who are at high risk. The program, provided through Medicaid

under contract with Central Plains Regional Health Care Foundation of the Sedgwick Medical Society, combines elements of case management, disease management and community care. The purpose of the program is to improve quality of care to high risk, chronically ill beneficiaries by working closely with health care providers in the community and coordinating all aspects of the individuals' care. Central Plains continues to pursue connections within the mental health delivery system, acute care delivery systems and rescue clinics in Sedgwick County to rapidly identify beneficiaries who would benefit from this project. KHPA is working with an independent contractor (Trajectory who is also evaluating the CHR) to conduct an impartial evaluation of the program.

The Kansas Health Policy Authority seeks to coordinate health and health care for a thriving Kansas. By strengthening health care purchasing through an emphasis on quality of care transparency and financial integrity, as well as focusing on partnerships with stakeholders, the agency has achieved increased efficiency and affordability in health care over the past year. We look forward to building on the success of 2006 and continuing our progress in upcoming years as we seek to expand health care coverage in Kansas.

Priorities of the Kansas Health Policy Authority for 2007

The year of 2007 will bring new challenges and priorities to the Kansas Health Policy Authority. To accomplish its mission of improving the health of Kansans, this agency will achieve these new goals, while continuing to strengthen the programs and operations currently under its purview.

- **Add staff to the Medicaid Eligibility Clearinghouse** to process applications and annual reviews for Medicaid beneficiaries in Kansas. The numbers of these applications and reviews have increased by an average of 1,089 per month between 2004 and 2005. In addition, new federal guidelines regarding citizenship and identification requirements have placed a burden on our Clearinghouse resulting in between 18,000-20,000 persons who are without coverage. Many are eligible Kansans whose applications are unable to be processed because of the lack of documentation gathered to meet the requirements. Some of the work done by the Clearinghouse is outsourced, and the contractors have requested additional staff to accommodate the increased workload. Also, by federal law, all Medicaid eligibility determinations must be finalized by state staff. As the number of applications increase, both the contractor and KHPA need additional staff to manage the increasing workload within mandated timeframes.
- **Complete staffing and infrastructure for the Authority** to operate as an independent agency and the single state agency responsible for the Medicaid program. When the initial levels of staff and budget transferred to the Division of Health Policy and Finance, the Kansas Department of Administration was providing infrastructure support. The Department of Administration continues to provide a limited number of services through a Memorandum of Agreement. However, the Authority is now an independent agency in need of completion of staff and resources to support its mission. The areas of additional support include accounting, auditing, human resources and information technology, among others. These resources are required to ensure the financial integrity of the programs administered by the Authority.
- **Develop a data management and policy analysis program** that promotes data driven health policy decisions, improving health care efficiency, lowering health care costs, and improving overall health status. The Authority is proposing to contract for the development of a data analytic interface that will bring various data sets together and provide staff with tools to access the data quickly and in more meaningful ways. Using data to analyze the efficiency and quality of health care services will enhance the ability of the state to better control health care costs in the public, and potentially, private sector, as well as increase the quality of health care.
- **Work with the Legislature and Governor's Office to pass a budget for FY 2008** which expands access to health care, implements new ways of information sharing and collaboration through Health Information Exchange, and increase

promotional efforts of health and wellness. The Kansas Health Policy Authority's priority initiatives for FY 2008 include the following:

- **Expand access to health care for children through the creation of a “Healthy Kansas First Five” Program**, which would expand low-cost insurance options through HealthWave to children age five and under from low and moderate income families who lack health insurance.
 - **Continuation of statewide Health Information Exchange** projects and support of HIE initiatives in other agencies through information sharing and collaboration.
 - **Provide greater health information transparency for consumers** by establishing a two-phase initiative that will 1) collect and make available health and health care data resources to consumers and 2) publicize costs and health care quality information developed by the Health Data Consortium for use by purchasers and consumers. The Health Data Consortium will advise the Board on the development of indicators.
 - **Allow coverage for dental services to adults** who are currently enrolled in the Kansas Medicaid program.
 - **Provide childhood obesity counseling through Kansas Medicaid**, which would include incentives for primary care providers to monitor body mass index, diet and physical activity.
 - **Increase awareness and education efforts about health and wellness and Medicaid eligibility.**
 - **Develop a Long Term Care (LTC) Partnership program** between KHPA, as the Medicaid agency, and the Kansas Insurance Department to encourage people to purchase LTC insurance policies.
- **Improve health care through additional initiatives** proposed for FY 2008, as follows:
 - **Expand the Enhanced Care Management (ECM) pilot project** to more high-risk beneficiaries with chronic diseases to improve the quality of care and appropriate health care utilization by adult Medicaid beneficiaries with chronic illness.
 - **Evaluate the Community Health Record (CHR) pilot program**, and if found effective, expand it statewide through a competitive bidding process.
 - **Link the state immunization registry with the Medicaid Management Information System (MMIS)** to target immunizations for all eligible beneficiaries.
 - **Improve Workplace Health and Wellness within the State Employee Health Plan** by developing a new health and productivity program built on an effective health risk assessment program which includes incentive design and delivery, web interactive programming, education, coaching and capture of appropriate data for future planning. Emphasis is being placed on tobacco cessation, obesity and diabetes management.

- **Re-tool the Small Business Health Partnership Program in collaboration with the Kansas Business Health Policy Committee (KBHPC)** to improve the accessibility and affordability of health insurance for small businesses.
- **Conduct studies** to foster e-prescribing for inclusion in the Medicaid program, examine the feasibility of consolidating prescription drug assistance programs in Kansas, analyze the impact of workforce shortages in rural and underserved areas, measure Medicaid beneficiary wellness, and explore Deficit Reduction Act (DRA) flexibilities in Kansas.
- **Involve consumers, providers, and purchasers** through Advisory Councils created to provide input and policy recommendations to the Kansas Health Policy Authority Board. The councils represent the multiple stakeholder groups from which the Board and KHPA must obtain support in order for policies to be supported and effective. The Consumer, Provider, and Purchaser Councils will begin meeting in March 2007.
- **Use established health indicators** to measure health and health care trends in Kansas. The health indicators will be used as measures to observe changes over time and track the impact of health policy initiatives and the Board's vision principles.

In light of the challenges we have ahead, particularly our need to complete staffing and infrastructure support, the Kansas Health Policy Authority Board has unanimously agreed to a recommendation not to transfer any additional programs to KHPA at the beginning of FY 2008. During 2007, the Kansas Health Policy Authority will continue to find new ways to improve existing programs and establish new initiatives that accomplish the mission of the agency. We intend to work with the Governor's Office, Legislature and stakeholders to provide Kansans with accessible and affordable health care.

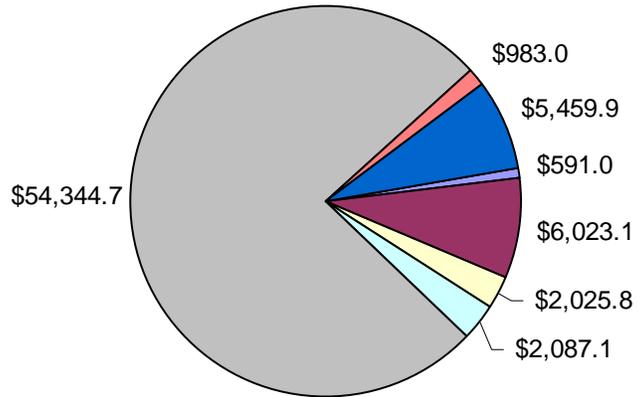
Programmatic Responsibilities

There are six programs established to assist with the mission of the Kansas Health Policy Authority.

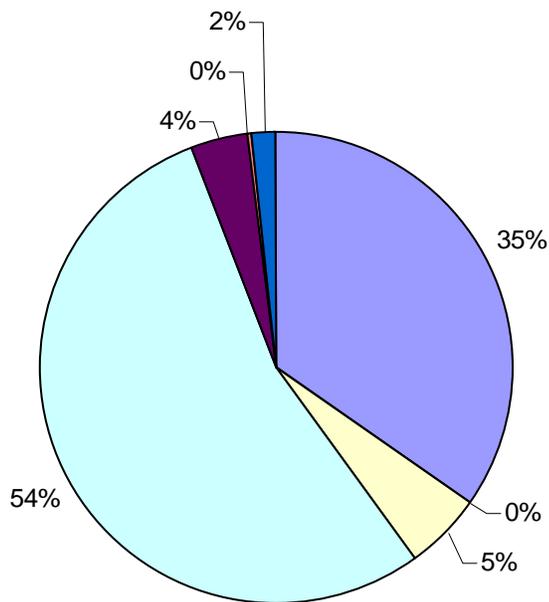
- **Executive Director's Office** oversees the operations and administrative responsibilities of the agency, as well as the statutory obligations and coordinates all programs established to assist with the mission and vision of the agency.
- **Operations and Finance Division** is responsible for the finance unit, which preserves the accurate fiscal management accurate reporting of KHPA's programs, and the operations unit, consisting of legal, audits, human resources, purchasing, facilities and information technology departments.
- **Quality and Innovation Division** is focused on health information exchange, quality and CommunityRx Kansas, and is charged with researching and developing innovative programs that will improve the quality, safety and efficiency of health care.
- The **Kansas Medicaid and HealthWave Division** develops policies and administers and manages programs that fund health care services for persons who qualify for Medicaid, MediKan, and the State Children's Health Insurance Program (SCHIP).
- **Data Policy and Evaluation Division** consolidates data management and analysis with policy evaluation, ensures accuracy of state employees' benefits enrollment data and options within the state payroll database, and researches new policy initiatives—all which work to uphold the mission of using data to make health policy decisions.
- **State Employees Benefits Division** manages and administers the state employee health, pharmacy, dental and vision insurance contracts. Responsibilities include customer service, state employee health and wellness programs, and developing value-added programs that will improve the quality and cost effectiveness of health care purchased by KHPA.

FY 2008 Governor's Budget Recommendation (Operating Expenditures in Thousands)

- Executive Director's Office
- Finance and Operations
- Quality and Innovation
- Data Policy and Evaluation
- Medicaid and HealthWave
- Other Federal Awards
- State Employee Health Benefits



Funding Sources for KHPA



- State General Fund
- Children's Initiatives Fund
- Fee Funds
- Title XIX
- Title XXI
- Other Federal Funds
- Other State Funds

Operations & Finance

The Finance unit is charged with the preservation of the fiscal management and accurate reporting of KHPA's programs. Key finance activities include managing the budget submission and adjustment processes, accurately reporting expenditures and revenues to the federal government, prudently managing cash balances, and managing receipts and receivables. The Accounting section manages all payables processing, including reconciliation of contractor pay tapes for provider payments, managing contract encumbrances, and developing management reports to guide decision making.

The Operations unit includes Legal, Audits, Human Resources, Purchasing, Facilities and Information Technology sections – all of which are geared toward improving the efficient and effective operation of the Authority:

- The Legal section is directed by a General Counsel and is responsible for advancing the Agency's mission through effective legal counsel and execution of specific programmatic activities, including those related to collection of third party claims (medical subrogation) as well as an Estate Recovery Unit, which recoups the costs of long term care from the estates of deceased Medicaid recipients. The section also provides counsel on contracting and interpretations of federal laws, regulations and state plan issues, and helps with other risk management issues.
- The Audits section tracks and provides assistance with resolution of external audits, provides management consultation to improve internal processes, validates program integrity, and leads the enterprise risk management program.
- Web publishing support, facilities, and the purchasing of commodities and non-program support services are also housed within Operations.
- KHPA, with the support of the Department of Administration, provides personnel services, including time keeping, payroll, recruitment, training, and evaluation.
- Information Technology section ensures the availability and appropriate use of computer and communication equipment for staff of KHPA and maintains data connections between KHPA, other state agencies, and contractors. The Division of Information Services and Communications provides technical support and customer service under contract with KHPA.

The Finance and Operations Division is lacking in staffing and infrastructure support, particularly in the areas of finance, accounting, auditing, human resources, and information technology. KHPA requested in a supplemental request for FY 2007 twenty-two additional staff positions and in an enhancement request for FY 2008 twenty additional staff positions. Upon conducting a needs assessment review in 2006, the Authority learned it was without many needed resources compared to other agencies. These resources are the minimum necessary to ensure the financial integrity of the programs that the Authority administers. The agency has requested additional funds to complete its staffing and infrastructure to operate as an independent agency and as the single state Medicaid agency.

Quality and Innovation

The Quality and Innovation (Q & I) Division focuses on health information exchange, quality and CommunityRx Kansas, and is charged with researching and developing innovative program that will improve the quality, safety and efficiency of health care.

- Health information exchange (HIE)
 - Serve as project lead for the statewide HIE initiative to develop infrastructure in Kansas that fosters health information technology adoption and health information exchange. This involves a collaborative relationship with stakeholders across the state including health care, business, government and patient advocacy leaders.
 - Serve as a liaison to the Governor's Office on HIE and staff the statewide HIE initiative, providing support for all initiatives, meeting coordination, information gathering, report production and contract management with consultants.
 - Manage consulting contracts and foundation funding received for HIE initiatives, working with major health foundations in Kansas, as well as national consulting groups and subject matter experts.
 - Manage the Community Health Record Pilot (CHR) project in Sedgwick County, working in partnership with Medicaid managed care health plans, providers, and technology vendors (Cerner Corporation and SureScripts) and an independent evaluation of the CHR. KHPA has requested for FY 2008 funds to extend this project to June 30, 2007. The information learned from the program will then be examined to evaluate the impact of the information technology on Medicaid providers and beneficiaries.
- Quality
 - Development of innovative programs focused on improving health care quality using principles of value-based purchasing and evidence-based medicine.
 - Development of incentives for providers and patients to improve safety and quality of care.
- CommunityRx Kansas
 - Generic drug program that provides affordable prescription medication to Kansans at or below 300% FPL and without prescription drug coverage, working in partnership with Kansas pharmacies and health care providers.

Kansas Medicaid and HealthWave Programs

The Kansas Medicaid and HealthWave Division develops policies and administers programs that fund health care services for persons who qualify for Medicaid, MediKan, and the State Children’s Health Insurance Program (SCHIP). Persons served by these programs include low-income children and adults, people with disabilities, and the elderly. In addition to administering cost-effective managed care (HealthWave) and fee-for-service (HealthConnect) purchasing systems, KHPA contracts with and oversees a fiscal agent that operates the Medicaid Management Information System (MMIS), ensures compliance with relevant federal rules and regulations and coordinates health care purchasing and planning among various state agencies.

Kansas Medicaid & HealthWave at a Glance	
Total Expenditures	\$2,225,438,000
Average Monthly Consumers	260,957
Unduplicated individuals	395,005
Providers	20,874
Average claims processed per day	39,267

Medicaid

Medicaid is a federal-state program that provides health and long-term care services to people with low-incomes. All states currently participate in the Medicaid program, and federal matching funds are available for the costs of these services. As a condition of state participation, each state must agree to cover certain populations (e.g., elderly poor receiving Social Security Income) and certain services (e.g., physician services). These eligibility groups and services are referred to as “mandatory” and include:

Mandatory Populations

- Children age 6 and older below 100% FPL (\$16,600 a year for a family of 3)
- Children between ages 1 and 6 below 133% FPL (\$22,078 a year for a family of 3)
- Parents below the state’s Aid to Families with Dependent Children (AFDC) cutoffs effective July 1996
- Pregnant women and infants (ages 0-1) at or below 150% FPL
- Elderly and disabled SSI beneficiaries with income at or below 75% FPL (\$7,500 a year for an individual)
- Certain working disabled
- Medicare Buy-In groups (Qualified Medicare Beneficiaries or QMBs, Specified Low Income Medicare Beneficiaries or SLMBs, and Qualifying Individuals or QIs)

Mandatory Acute Care Benefits

- Physician services
- Laboratory and x-ray services
- Inpatient hospital services
- Outpatient hospital services

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- Early and periodic-screening, diagnostic, and treatment (EPSDT) services for individuals under 21
- Family planning and supplies
- Federally-qualified health center (FQHC) services
- Rural health clinic services
- Nurse midwife services
- Certified pediatric and family nurse practitioner services

Mandatory Long-Term Care Benefits

- Institutional Services—Nursing facility (NF) services for individuals 21 or over

State Children's Health Insurance Program (SCHIP)

SCHIP is a federal-state partnership similar to Medicaid. The program was designed to provide coverage to “targeted low-income children.” A “targeted low-income child” is one who resides in a family with income below 200% of the Federal Poverty Level (FPL) or whose family has an income fifty percent higher than the state’s Medicaid eligibility threshold. Kansas provides free or low-cost health insurance coverage to children in this program who:

- Are under the age of nineteen;
- Do not qualify for Medicaid;
- Have family incomes under the 200% of the FPL; and
- Are not covered by state employee health insurance or other private health insurance.

Nearly all health care services purchased by Medicaid and HealthWave are financed through a combination of state funds and federal matching funds authorized through Medicaid or SCHIP of the Social Security Act of 1965. Under Medicaid, the federal government provides approximately sixty percent of the cost of Medicaid services with no upper limit on what the federal government will reimburse the State. The State provides the remaining forty percent of the cost of Medicaid services. Under SCHIP, the federal government provides approximately 72 percent of the cost up to a maximum allotment, and the State provides the remaining 28 percent and any excess spent above the federal allotment.

In FY 2006, the State of Kansas spent over \$1 billion purchasing health care for more than 360,000 persons through the Medicaid and HealthWave programs. It is the third largest purchaser of health care services and the largest purchaser of children’s health care services in Kansas. About 64 percent of the people served were low-income children and families. Medicaid pays for nearly forty percent of the births in Kansas.

Purchasing Health Care

Health care services are purchased through both a traditional fee-for-service model and two different managed care models (HealthWave and HealthConnect). In the fee-for-service model, Medicaid consumers can receive services from any enrolled provider without having a primary care physician (PCP). In HealthConnect, services to providers are paid on a fee-for-service

basis, but physicians also receive a monthly per person payment to serve as PCPs and provide a medical home for Medicaid consumers. This model is referred to as a primary care case management (PCCM) model. HealthWave, a capitated managed care program, is funded through per member per month payments to managed care organizations (MCOs) that assume risk for health care costs of Medicaid consumers who exceed monthly capitation amounts.

The Center for Medicare and Medicaid Services (CMS) requires that Medicaid consumers have a choice of either their health plan, or within a fee-for-service model, their provider. Deviations from this requirement are available only through a CMS waiver. SCHIP populations are not subject to this “freedom-of-choice” requirement, and according to state law, they must receive physical health services through a capitated managed care model. Nevertheless, KHPA provides a choice of health plans to both Medicaid and SCHIP consumers participating in the HealthWave program and generally offers a choice of providers to both its HealthConnect and HealthWave populations. The HealthWave population consists of Temporary Assistance to Families (TAF) and Poverty Level Eligibles (PLE). These groups typically consist of pregnant women, children, and very low-income adults who do not qualify as chronically ill. The HealthConnect population includes these same eligible groups in those areas where HealthConnect is a choice as well as Social Security Income eligible persons and MediKan persons. Social Security Income eligible children, Title V children and Native Americans are exempt from managed care assignment to HealthWave or HealthConnect. This is also true for persons in nursing homes, persons on an HCBS waiver, and those eligible under the medically needy programs. These persons are served fee-for-service and are not assigned to HealthConnect.

Within the broad population of children and low-income families, there is a great deal of overlap and movement between those eligible for Medicaid and those eligible for SCHIP. Due to the age-related eligibility requirements, about a quarter of families with a child in SCHIP also have a child in Medicaid. Because economic and family circumstances often change, the majority of families enrolled in SCHIP have previously been enrolled in Medicaid. This overlap between the low-income children and families enrolled in Medicaid and SCHIP helps motivate the provision of care through a singular, integrated program for this population, called HealthWave.

HealthWave

During FY 2002, the marketing of the Medicaid capitated managed care program was combined with the SCHIP program to provide one seamless managed care option for families called HealthWave. Combining these two programs into one managed care option has provided eligible children and families with more uniform and seamless physical health coverage, regardless of which federal government program funds the coverage. As of January 2007, 106,494 persons were enrolled in Medicaid, and 34,791 persons were enrolled in SCHIP.

Managed Care Organizations (MCOs) provide health insurance coverage for those consumers eligible for HealthWave. The responsibilities of the MCO may range from utilization management services to the actual provision of the services through its own organization or provider network. Reimbursement for these services is paid on a capitated per member per month basis. Consumers enrolled in HealthWave are given the opportunity to select a primary care physician to coordinate their health care service needs. If they do not elect to make this

choice, the MCOs assign a primary care physician in their area. KHPA emphasizes access to care, provider participation, and the quality of care provided to its HealthWave populations through contractual requirements and standards with its MCOs. A specific emphasis is placed on the development of a managed system of care that promotes long-term health and wellness.

On January 1, 2007, UniCare Health Systems and Children's Mercy Family Health Partners became the physical health MCOs for Medicaid eligible and SCHIP consumers. Cenpatico Behavioral Health is the MCO providing mental health services to consumers who are SCHIP eligible. Doral Dental, Inc. was the MCO for SCHIP dental services until July 1, 2006. The state SCHIP statute exempts dental services from the general requirement to provide SCHIP services through a capitated managed care arrangement. On July 1, KHPA exercised this flexibility to create a more streamlined dental program that is identical in service delivery, coverage, and payment across both the HealthWave and HealthConnect programs. Dental services are now provided on a fee-for-service basis for all populations through Electronic Data System, the state's Medicaid Fiscal Agent, on July 1, 2006.

HealthConnect

For those persons not covered by HealthWave or in the traditional fee-for-service program, KMAP provides health coverage through the Primary Care Case Management (PCCM) model called HealthConnect. Many of the individuals in this portion of Medicaid program are frail elderly or have disabilities, and by federal rule, they cannot be served by a managed care program.

As of January 2007, there were 24,560 persons served by HealthConnect. This model provides preventive and primary medical services and refers individuals to specialists when necessary. Kansans eligible for these health coverage options include those eligible for Temporary Assistance to Families program (TAF); people enrolled in the Supplemental Security Income (SSI) program, General Assistance (GA) program, and Poverty Level Eligible (PLE) individuals. The HealthConnect provider receives a case management fee of \$2 per member per month and services are reimbursed on a fee-for-service basis.

Programs to support the mission

- *Drug Utilization Review Program.* Each state's Medicaid program has a Drug Utilization Review (DUR) program for outpatient drugs that retrospectively reviews drug utilization patterns. The information then is used to educate prescribers and pharmacists about drug utilization trends and improve safety and quality of care. The DUR Board, comprised of physicians, pharmacists and mid-level practitioners, is responsible for making recommendations to the Medicaid program regarding drug therapy issues.
- *Preferred Drug List (PDL).* A preferred drug list (PDL) was created to promote quality, clinically appropriate utilization of pharmaceuticals in a cost-effective manner. A Preferred Drug List Advisory Board, composed of practicing physicians and pharmacists, provides extensive clinical review of drug products for consideration of inclusion on the PDL. The Advisory Board is not provided with Medicaid's drug cost information to

ensure that their review and recommendations are based solely on clinical evidence. Medicaid staff then take the PDL Board's clinical decision and incorporate cost information to make a recommendation for inclusion on the Medicaid PDL. These recommendations are then taken to the Drug Utilization Review Board for review and approval in accordance with K.S.A. 39-7,118. The drugs that are placed on prior authorization go through the rules and regulations process, and there is a 30-day public comment period before the prior authorization is effective.

- *Estate Recovery.* The Estate Recovery Program recovers medical care cost from the estates of certain deceased Medicaid persons. The Estate Recovery Unit (ERU) has recouped approximately \$40 million from 19,000 cases since the program began July 1, 1992. The State of Kansas retains approximately forty percent of all monies recovered. Under 42 U.S.C. 1396p, KHPA is allowed to establish a claim for Medicaid on persons who, prior to their death, have received medical assistance from age 55 and older or who are in a long-term care facility regardless of age. The claim is based on the medical assistance a consumer has received on and after July 1, 1992. The ERU mainly recovers through probate actions and family agreements. If there is a surviving spouse, surviving child under the age of 21 years, blind or permanently disabled according to Social Security criteria, the unit does not pursue a claim at that time. A claim can be filed upon the death of the surviving spouse. The medical assistance claim is a first class demand with priority being granted to reasonable funeral expenses within the class. At present, no liens are filed against the property of a person or spouse in order to establish a claim prior to death. The claim is filed against property still available at the time of death. Beginning July 1, 2004, ERU was given increased authority to recover property through liens and expanded court actions involving an expanded definition of a probate estate.
- *Medical subrogation and third party liability.* The medical subrogation and third party liability programs enhance Medicaid's position as payer of last resort. Medical subrogation is authorized by K.S.A. 39-719a. When medical assistance has been paid and a third party becomes legally liable for the payment of those same medical expenses, the Medicaid program may recover the amount of medical expenses it paid to the recipient. Federal law and regulations require states to assure that Medicaid recipients utilize all other resources available to pay for medical care before turning to Medicaid. Accordingly, the third party liability program (TPL) identifies and seeks reimbursement from private health insurance, employment-related health insurance, medical support from absent parents, automobile insurance, court judgments or settlements from a liability insurer, state worker's compensation, first party probate recovery and other federal programs such as Tricare, veterans benefits, or Medicare.¹

New citizenship guidelines for applicants of Medicaid and SCHIP programs

¹ Pursuant to K.S.A. 39-709c Medicaid expenditures are noted elsewhere in this report. For FY 2006, total recoveries from the Estate Recovery Program were: \$4,502,592; total recoveries from the Medical Subrogation Program were: \$1,457,617.92; total recoveries from the Third Party Liability Program were: \$354,314,282.20. There is only one legislative item contemplated for these programs in 2007, a bill to enhance third party liability efforts will be introduced as required by the Deficit Reduction Act. The bill expands the definition of potential third party payers and lengthens the time for collection.

New federal requirements, effective July 1, 2006, require many Medicaid applicants to provide documentation verifying their citizenship and identity. These requirements have created challenges for beneficiaries and significant additional workload for state eligibility workers. As a result, between 18,000 and 20,000 persons are without coverage, including many who will ultimately succeed in demonstrating their citizenship and identity. KHPA staff have re-engineered enrollment and utilized electronic verification where appropriate but will not be able to address the new workload without additional resources. KHPA is recommending that Congress revisit the legislation to consider the impact on state and beneficiaries.

The new federal laws do not change eligibility rules but instead require applicants to provide certain documents verifying that they comply with rules governing citizenship and identity. The new laws require applicants, including those renewing their eligibility, to document citizenship and identity through a primary document, which verifies both citizenship and identity (passport or certificate of naturalization), or separate secondary documents, one verifying citizenship, such as a birth certificate, and another verifying identity, such as a driver's license or school picture ID.

These new requirements have had a large impact on the enrollment process in Kansas, increasing customer calls, voicemails, faxes, and the amount of time it takes to process an application has multiplied. As a result, the number of individuals enrolled in Kansas Medicaid or SCHIP has fallen by thousands since the requirement went into effect. Of those who were dropped in this caseload estimate, 2,381 individuals' applications or renewal cases have been closed, because they could not provide the newly required documents in a timely fashion. Another 16,000 or more are waiting to enroll in the program or have fallen off the program while waiting to be re-enrolled, as a result of the large backlog of cases the new requirements have created. Many of those waiting to be enrolled are eligible citizens. Based on historical averages, the majority of children and families with pending applications will qualify for coverage under the new requirements when we are able to complete processing.

The impact on beneficiaries is real and growing. KHPA and SRS eligibility workers have received hundreds of calls from customers or applicants with pressing medical needs that require insurance coverage. Some safety net providers reported a change in the coverage status of their patient population.

To reduce the impact on beneficiaries, KHPA is utilizing approved and reliable electronic sources of documentation and resources at the Clearinghouse have been reallocated and enrollment processing has been adjusted to accommodate the new documentation requirements. KHPA will also be calling on our Congressional delegation to provide an update on the impact of these new laws, suggest policy alternatives, and recommend a Congressional review of the legislation.

Outreach efforts continue

Identifying uninsured families has long been a goal of Kansas, and the placement of outreach workers at key locations throughout the community will increase the awareness of the

opportunity for coverage. As families obtain coverage, they are more likely to access preventive medicine, including well child visits, immunizations, and dental care.

KHPA plans to expand the marketing of programs available to the public, such as Medicaid and SCHIP, in order to educate Kansans about health and wellness and ensure that individuals eligible for Medicaid and SCHIP are participating in the program. Plans include designing an online application and screening tool for potential beneficiaries, developing and implementing a targeting marketing campaign, and employing additional outreach workers. This would allow for more accurate submission of applications, development of an inter-face with the Clearinghouse system for an immediate eligibility determination, and reduce the need for Clearinghouse staff to “key” the applications. A screening tool could be used to quickly determine if a person should complete an application and utilized by designated entities as the presumptive eligibility determination tool.

These plans, requested in the FY 2008 budget, will provide KHPA an opportunity to share health information with potential Medicaid beneficiaries. It will increase our outreach efforts, and the goal is to increase the number of uninsured Kansans who have medical coverage.

2007 KHPA Annual Legislative Report

Medical Assistance Expenditures

Title XIX Medicaid	FY 2006 Actuals	FY 2007 Revised	FY 2008 Gov Recommendation
Expenditures	1,802,541,709	1,158,710,000	1,241,727,483
Persons Served Each Month	264,980	259,758	265,811

Title XXI HealthWave	FY 2006 Actuals	FY 2007 Revised	FY 2008 Gov Recommendation
Expenditures	62,803,428	69,302,363	69,302,363
Persons Served Each Month	36,824	35,588	36,604

MediKan	FY 2006 Actuals	FY 2007 Revised	FY 2008 Gov Recommendation
Expenditures	23,321,000	23,290,000	14,010,000
Persons Served Each Month	4,434	3,758	2,236

Medical Assistance Revenue Sources

	FY 2006 Actuals	FY 2007 Revised	FY 2008 Gov Recommendation
State General Fund	401,701,255	422,130,917	466,425,910
Children's Initiative Fund	5,415,325	5,000,000	-
Medical Programs Fee Fund	36,847,819	43,400,000	38,500,000
Health Care Access Improvement Fund	41,426,936	37,390,236	37,390,236
Title XIX Medicaid	1,351,731,210	690,655,522	729,998,012
Title XXI HealthWave	45,647,705	50,171,446	50,171,446
Other Federal Funds	5,895,887	2,554,242	2,554,242

Data Policy and Evaluation

KHPA is charged with the responsibility for a wide range of health and health care data including both programmatic and market-based information. The goal is to increase the quality, efficiency, and effectiveness of health services and public health programs.

To meet this mission, the Division of Data Policy and Evaluation consolidates data management and analysis with policy evaluation. All program data is available to analysts to assess the impact of proposed policies, forecast utilization and expenditures, and provide information to the Authority Board, KHPA staff, and other stakeholders. This division is also responsible for ensuring the accuracy of the state employees' benefits enrollment data and options within the state personnel database and for researching new policy initiatives.

Examples of programmatic data include Medicaid and SCHIP, State Employees Health Benefits Plan, and State Employees Self-Insurance Fund (Workers' Compensation). Market-based data are inpatient hospital claims information, health care provider database, and private insurance data from the Kansas Health Insurance Information System (KHIIS).

House Substitute for Senate Bill 272, the enabling legislation for the Kansas Health Policy Authority (KHPA) transfers responsibility for collection and management of a wide range of data once managed by the Health Care Data Governing Board (HCDGB) to the Authority. In addition, House Substitute for Senate Bill 577 transferred responsibility for collection of data from insurance carriers on behalf of the Commissioner of Insurance from the Kansas Department of Health and Environment (KDHE) to KHPA.

To help meet the Authority's responsibilities, KHPA will convene and direct the Data Consortium to advise the Authority in the development of policies and bring recommendations to the Authority for consideration.

The Data Consortium will provide recommendations and input in a number of areas:

- The Authority's responsibilities for managing health data
- Reporting standards and requirements for non-programmatic data
- Data sharing for research, policy development and programmatic improvement
- Identifying specific topics for analysis
- Health and health care data initiatives in other organizations and agencies
- Reporting cost, quality, and other data for consumers, policymakers, and others

Programs to support the mission

- The **Director of the Division of Data Policy and Evaluation** promotes the collection, management, analysis, and dissemination of health data to improve decision-making by consumers, in the marketplace, and among policy makers. This includes developing a plan to maximize the effective use of health data by supporting the activities of the KHPA Data Consortium.

- The **Data Analysis Unit** establishes reimbursement rates, computes the fiscal impact of proposed policies, establishes diagnosis-related groups (DRGs) for Medicaid inpatient services, establishes capitation rates for Medicaid and SCHIP managed care, and forecasts caseloads.
- The **Data Policy and Management Unit** is responsible for management of health care professional licensure data received from eight licensing boards, hospital discharge data received from the Kansas Hospital Association (KHA), and private insurance carrier data required by the Commissioner of Insurance (known as the Kansas Health Insurance Information System-KHIIS). This unit also plans to manage the vendor contract for a data analytic interface allowing KHPA staff and stakeholders to access KHPA-managed data more easily and quickly.
- The **Policy Evaluation Unit** explores emerging health, health care and coverage issues; manages state and federally funded research projects; and estimates the impact of proposed coverage changes in the State Employees Health Plan. In addition, staff in this unit also set up, review and analyze benefits eligibility in the state personnel database, and monitor files, reports, and eligibility data for completeness and accuracy.

State Employees Health Benefits and Plan Purchasing

The State Employee Health Benefits and Plan Purchasing Division:

- Manages and administers health, pharmacy, dental and vision insurance contracts for State employees and their dependents;
- Manages the state employee health and wellness programs;
- Manages and administers the State Employees Self Insurance Fund (Workers' Compensation);
- Oversees the Customer Service Unit which provides an integrated approach—regardless of program—to health care consumers for solving or avoiding problems related to eligibility, enrollment, coverage or payment issues, and providing for improved access to information.
- And develops value-added programs that will improve the quality and cost-effectiveness of health care purchased by the KHPA, which includes:
 - Employee health and wellness;
 - HealthQuest, the state employee wellness program;
 - Health Risk Assessment and Health Risk Screening;
 - Disease management; and
 - Partners with KDHE and other state agencies to coordinate health and wellness statewide.

State Employees Benefits Program at a Glance	
State Employees	35,100
Non-State employees	5,777
Dependents	30,247
Retirees	9,011
COBRA	182
Total Individuals Covered	80,317

The State Employee Health Benefits and Plan Purchasing administer health insurance contracts for state employees and their dependents. The State Employee Health Plan is overseen by the State's Health Care Commission (HCC), which was statutorily created in 1984 through the enactment of K.S.A. 75-6501, *et seq*, to “develop and provide for the implementation and administration of a state healthcare benefits program.”

Over the years, the number of contracts and types of people covered by the program has expanded. Beneficiaries receiving health insurance services through the plan include active, retired, disabled State employees and their dependents, people on leave without pay, elected officials, blind vending facility operators, and employees of school districts, community colleges and other educational entities. The local government employer components include cities, counties, townships, community mental health centers, groundwater management districts, rural water supply districts, public wholesale water supply districts, county extension councils and extension districts.

Most recently, through an amendment to regulation 108-1-4, voluntary enrollment was extended to hospitals established, maintained and operated by a city of the first or second class, a county or a hospital district in accordance with applicable law. There has been steady growth in the Non-State Group Plan, particularly among small group employers. Most of the new groups added have had enrollments of less than five members.

Health Plan Enrollment

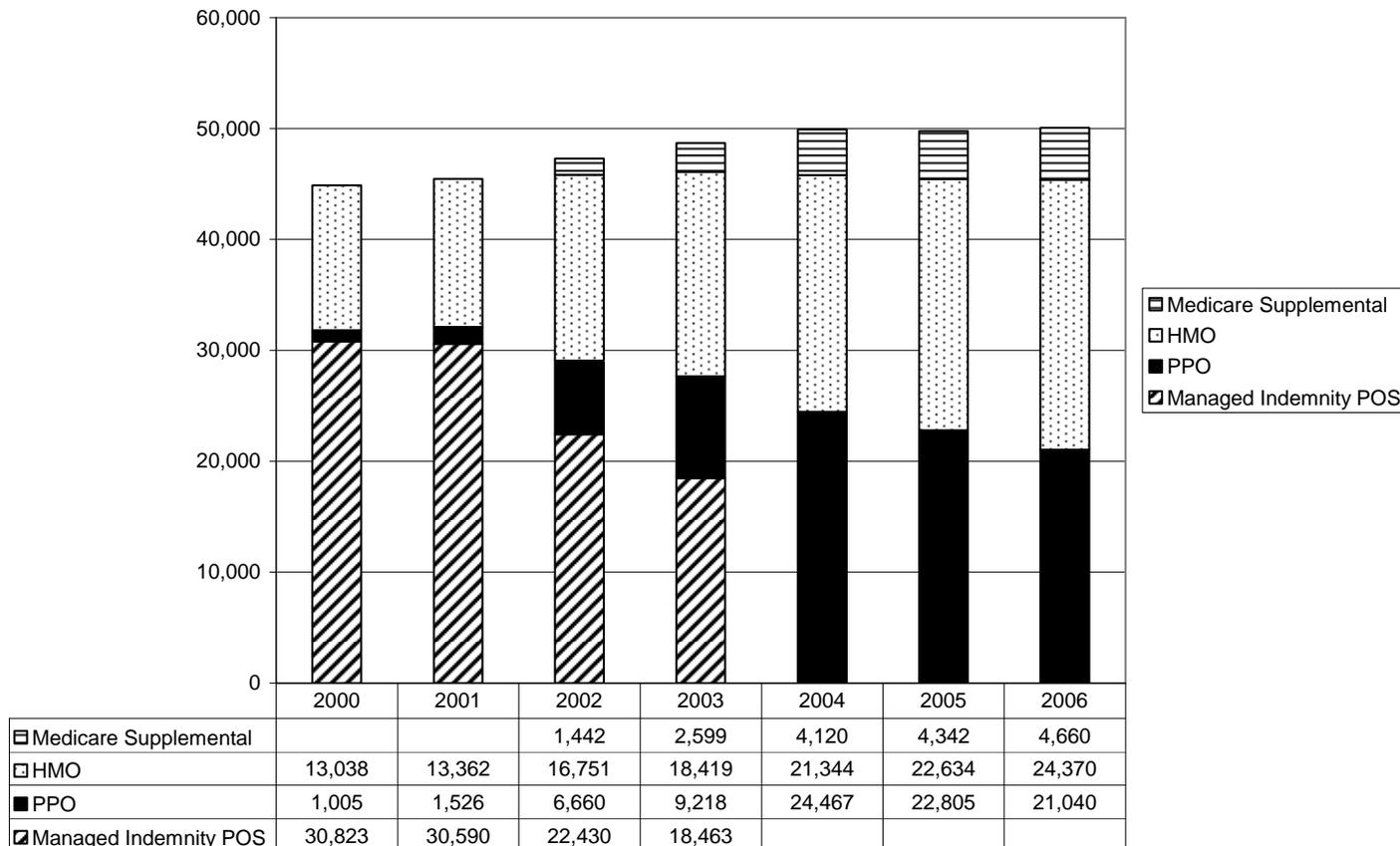
Total plan enrollment in the State Employee Health Plan is 50,070 contracts and 88,226 covered lives. In plan year 2006, 92 percent of eligible employees were enrolled. Of those, 56 percent carried single coverage and 44 percent provided coverage for their dependents.

There are 98 Non-State group employers participating in the plan, consisting mostly of schools and municipalities. The Non-State group employers include 35 school districts; 44 cities, counties or townships; and 19 other local units such as a hospital, mental health center, libraries and extensions. The number of participants in the Non-State groups range from 1 to 588. Only 4 groups have more than 200 and 13 have between 100 and 200 members.

In addition to the active employees, KHPA provides coverage for nearly 9,000 retirees and former employees living in all states and some abroad.

Participation in the plans include active employees, retirees, employees receiving long-term disability payments, employees on leave without pay, Non-State employer groups, qualified beneficiaries on COBRA, as well as other individuals identified on K.A.R. 108-1-1, K.A.R. 108-1-3, and K.A.R. 108-1-4. On June 30, 2006, at the end of FY 2006, there were 50,070 contracts covering 88,226 lives. The contracts included:

Number of Contracts by Plan Type



Health Plans

Medical. All participants have a choice of preferred provider organizations (PPOs) and, where available, a Health Maintenance Organization (HMO) option as well. For plan year 2006, 63 percent of State of Kansas active participants chose an HMO. Retirees who are Medicare eligible also can enroll in a self-funded Medicare Supplement Plan and, beginning with 2006, a Medicare Advantage Plan offered by Coventry. Retirees have the same choices of health plans. Approximately \$101 million was spent in 2006 on medical claims for the self-funded plans administered by Blue Cross Blue Shield and about \$126 million in premiums for the fully insured plans.

Prescription Drugs. Prescription drugs are carved out of the health plans and are self-funded. They are administered by Caremark, a pharmacy benefits manager. The plan design includes a tiered coinsurance program with a separate co-payment for special case medications and discounts for lifestyle drugs. The generic dispensing rate for the state employee plan has grown to over 55.7 percent. Annual claims cost for 2006 was \$60 million.

Dental. The dental component is a self-funded plan administered by Delta Dental of Kansas. Dental coverage is provided by the employer for employees at no cost, and it is optional for dependents. In 2006, \$19.4 million was paid in claims.

Vision. Two voluntary vision plans are offered to employees from Superior Vision. There are 8,179 State of Kansas employees enrolled in the basic plan and 14,249 enrolled in the enhanced plan. The vision premiums are entirely employee-paid.

Employee Health and Wellness. HealthQuest was instituted in 1988 to provide wellness programs with the goal of improving employee health and reducing health care costs. Programs have included periodic health risk appraisals and screening, disease management, employee assistance counseling and referrals, life coaching, healthy weight classes, wellness newsletter and a health blog, as well as wellness presentations for employee groups across Kansas.

Disease management. Disease management programs currently offered by the State Employees Health Benefits Program are through the contracted health and prescription drug plans/vendors and include coronary artery disease, diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD). Participation and results are tracked and monitored by the health plans and results are reported to the contract management team.

Health and Wellness

KHPA plans to expand the focus on health and wellness policies within the State Employee Health Benefits and Plan Purchasing (SEHBP) and significantly increase the focus on health and wellness in the State Employee Health Plan for the 2008 plan year with the goal of improving health and decreasing overall health costs, beginning with the new health risk appraisal program in the fall of 2007. KHPA will be implementing a full program in 2008. This will include

incentives and rewards for participation, with a focus on tobacco cessation, obesity, diabetes, health behavior, chronic disease management plan, improved fitness, and improved nutrition.

KHPA intends to research and implement value-based health plan designs beginning in summer of 2007. We anticipate these models will be modified to include the Medicaid population in the future.

HealthQuest staff will partner with KDHE on a comprehensive employee health and wellness plan for the entire state. Plans are already under way for HealthQuest and KDHE to work together to implement a comprehensive tobacco cessation initiative that provides incentives for employees to quit and provides them resources to do so. We plan to partner with additional agencies and community organizations to promote workplace wellness.

State Employees Self Insurance Fund (Workers' Compensation)

The Workers' Compensation program for state employees is called the State Employees Self Insurance Fund (SSIF). The SSIF is funded by agency rates based on experience rating. The rates are developed by an actuarial service using three years of claims experience, payroll and caps on expenses, and are currently approved by the Department of Administration and published by the Division of Budget.

The SSIF processes and manages claims for injuries that arise out of and in the course of work. There is unlimited medical compensation to treat the injury. Additionally, compensation is made for loss of time, permanent impairment or death. Medical payments are based on a fee schedule developed by the Workers' Compensation Division of the Kansas Department of Labor. A third-party medical review service is utilized to review claims for medical appropriateness and pricing. On average, 327 accident reports are received monthly. In FY 2006, the SSIF spent over \$16.7 million on compensation, with about 59 percent for medical services and 41 percent for loss time compensation.

It is the intent of KHPA to include Workers' Compensation in as many health promotion and wellness programs as possible.

Conclusion

As the leading state agency on health, health care, and health policy, we are committed to ensuring Kansans have access to quality, affordable, and sustainable health care. The Kansas Health Policy Authority's Annual Legislative Report provides a snapshot of important work we continue to accomplish at this agency. It also has demonstrated the upcoming challenges and goals of 2007. We will continue to provide this report to the Legislature on a yearly basis, and look forward to working with them to ensure this agency is meeting the mission the Legislature entrusted to us.

-Marcia Nielsen, Ph.D, MPH, Executive Director of the Kansas Health Policy Authority