MINUTES

JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT

June 12, 2009
Room 143-N—Statehouse

Members Present

Senator Jim Barnett, Chairperson
Representative Brenda Landwehr, Vice-chairperson
Senator Jeff Colyer
Senator Laura Kelly
Senator Vicki Schmidt (Afternoon)
Representative Bob Bethell
Representative Don Hill
Representative Peggy Mast
Representative Jim Ward

Members Absent

Senator David Haley (Excused)
Senator Roger Reitz (Excused)
Representative Louis Ruiz (Excused)

Staff Present

Terri Weber, Kansas Legislative Research Department
Reed Holwegner, Kansas Legislative Research Department
Kelly Navinsky-Wenzl, Kansas Legislative Research Department
Amy Deckard, Kansas Legislative Research Department
Nobuko Folmsbee, Office of the Revisor of Statutes
Doug Taylor, Office of the Revisor of Statutes
Jan Lunn, Committee Secretary

Morning Session

Chairman Barnett called the meeting to order at 10:03 a.m. Contents of the Committee members' packets were reviewed. They included:

- Membership list and Committee charge (Attachment 1);
- Preliminary Minutes of the March 19, 2009 meeting (Attachment 2);
- Report of the Joint Committee on Health Policy Oversight to the 2009 Kansas Legislature (Attachment 3); and
- A draft appreciation letter to Dr. Marcia Nielsen for possible action by the Committee (Attachment 4).

Upon a motion by Representative Bethell and a second by Representative Landwehr to approve the minutes of the March 19, 2009 meeting, the motion passed unanimously.

Chairperson Barnett announced that Senator Haley and Representative Ruiz were attending national conferences, and therefore, were excused from the Committee meeting.

Chairperson Barnett provided an overview of the Committee's oversight role in the long-range program review of the Kansas Health Policy Authority (KHPA). He indicated oversight can be useful in both monitoring the overall direction and progress of the agency, as well as anticipating and addressing problems as they arise. In addition, the purpose of the review is to examine KHPA's performance over a period of time in anticipation of legislative consideration of the agency's sunset date of July 1, 2013. Chairperson Barnett reviewed the following documents, previously distributed to Committee members and discussed at the March 19, 2009 meeting: The Oversight Process, Recommendations for Oversight, and Targeted Review Guidelines (see March 19, 2009, minutes).

Chairperson Barnett further indicated that any oversight process must be viewed by stakeholders as fair, specific, measurable, credible, and likely to produce meaningful results. Any process should follow general principles of oversight to ensure objectivity, transparency, and integrity of results.

Mr. Joe Tilghman, Chairperson, KHPA Board, was recognized to respond and to provide comments regarding the oversight documents reviewed by Committee members (Attachment 5).

Mr. Tilghman began by introducing Dr. Andy Allison, KHPA's Interim Director, who has replaced Dr. Marcia Nielsen, former Executive Director. Mr. Tilghman briefly reviewed the current status of activities at KHPA, including a scheduled retreat in the upcoming weeks; hiring an Inspector General; monitoring Washington, D.C. developments; reconfiguring KHPA's staffing to reflect recent budget reductions; developing policies to reduce the financial impact on safety net providers; and continuing to play a key role in Health Information Technology/Health Information Exchange (HIT/HIE) development.

The second portion of Mr. Tilghman's comments centered on the oversight process. He indicated a comprehensive, well-structured review process was welcome. The KHPA Board was comfortable with proceeding with the draft as presented. Mr. Tilghman did provide some cautionary thoughts that encouraged policy continuity through changes in leadership roles (Legislature and Governor), the necessity of benchmarks to improve evaluation interpretation, and the necessity to provide flexibility to respond to a changing world and environment.

Committee members responded to Mr. Tilghman's comments with questions related to the Office of the Inspector General (OIG) and whether location of that office should be with an agency

other than the KHPA; the apparent declining morale within the staff at the KHPA in light of recent position abolishment; and the creation of a closer tie between the Governor's Office and KHPA that will focus on provision of services while bringing into perspective good policy and actions.

Mr. Tilghman indicated there may be recommended changes regarding the OIG; additional communication and dialogue will occur with KHPA staff; and additional communication with the Governor's Office will occur should the recommended oversight process be implemented. Senator Barnett requested that Mr. Tilghman furnish any additional feedback to Terri Weber, Legislative Research Department, and to Gina Maree, Kansas Health Institute.

Dr. Andy Allison, Interim Director, KHPA, commented that he believed the oversight process to be structured and well-ordered. He reported that the agenda for the upcoming retreat includes updating KHPA's Strategic Plan. In addition, he recognized the importance of the legislative process, and the impact of a changing environment on policy and performance.

Upon a motion by Representative Bethell and a second by Representative Mast to adopt the oversight process as outlined in the documents entitled (1) Oversight Process, (2) Recommendations for Oversight, and (3) Targeted Review Guidelines, the motion passed.

Dr. Allison submitted an "Update from the Kansas Health Policy Authority: Impact of FY 2010 Budget Decisions" (Attachment 6). Dr. Allison reviewed Medicaid transformation and savings estimates for FY 2010, discussed 2008-09 recommendations, and provided a summary of FY 2010 budget decisions. Discussion ensued related to savings estimates, particularly in pharmaceuticals, and the development of an advisory committee to assist in the area of mental health prescription drugs.

Representative Bethell requested additional information on the Pharmaceutical Advisory Committee, its membership qualifications, term lengths, purpose, and a list of selected members. Dr. Allison stated that he will furnish the requested information.

Considerable discussion was heard related to KHPA's budget, efficiencies, and savings. Key points included:

- Programs and operations are funded separately;
- Caseload costs are 20 times greater than operational costs; and
- Any caseload savings cannot be credited to cost-saving operations.

Related to the discussion of the FY 2009 KHPA budget, Senator Kelly inquired if KHPA could tell what the impact would have been on KHPA's FY 2009 budget if the stimulus money had not been received. Dr. Allison responded that he would provide that information to Senator Kelly and Committee members at a later time. Senator Kelly requested a definition of the term "firewall" as it relates to caseload savings and cost-saving operations. Dr. Allison explained that the "firewall" is the caseload consensus funding process. Each time caseload funding is forecast, KHPA staff prepare a detailed analysis of what changed, why changes were recommended, and the amount of changes.

Senator Colyer stated that in FY 2009, $500,000 was allocated to provide dental benefits to pregnant mothers. The program was to be administered through the KHPA and was projected to generate significant caseload savings. Senator Colyer asked for an update on implementation of this program. Dr. Allison reported that as of the current date, the program had not been implemented. The services are funded from the legislative appropriation of $500,000. At this time,

these funds remain unspent because there was no appropriation for the operational costs (including implementation). Discussion followed in which Committee members discussed the necessity to include legislative notification when money has been appropriated but implementation and operational costs have not been appropriated. Representative Landwehr inquired from what source the $500,000 figure for pregnant women dental services came and whether there were other state-funded programs with unspent appropriations. Representative Bethell questioned what the ramp-up costs for this program would be. Representative Ward expressed doubt that the program could be implemented given current staffing reductions resulting from the budget deficit. Senator Barnett requested that Dr. Allison provide responses to the Committee's concerns, and that this item be added to the next Committee agenda for additional discussion.

Representative Bethell inquired about the rationale of discontinuing programs that save the state money, specifically, the Enhanced Care Management Program. Dr. Allison responded that the challenge is reducing operational costs and leveraging the return either to beneficiaries or savings to the State.

Additional discussion was heard related to budget cuts and how KHPA staff determined reductions; staffing and morale issues; outsourcing; the impact of staffing cuts on beneficiaries and services; clearinghouse issues; the percentages of clean and unclean claims; and the impact of KHPA operational cuts. Senator Kelly questioned whether there was any data tracking of the relationship between budget cuts and emergency room visits or uncompensated emergency room costs. Dr. Allison indicated he would investigate how that issue could be evaluated. Representative Bethell conveyed the importance of communication with the Legislature if efficiencies identified and implemented by KHPA negatively impact services and beneficiaries.

Vice-Chairperon Landwehr commented concerning healthcare reform and health insurance reform, transparency, cost reductions, new products, and accessibility.

The meeting recessed for lunch.

Afternoon Session

The meeting reconvened at 1:40 p.m.

Cathy Harding, Executive Director, Kansas Association for the Medically Underserved, was recognized by Vice-Chairperson Landwehr. Ms. Harding presented information related to the agency's history, purpose, and mission. Ms. Harding discussed current and long-range planning for Kansas safety net clinics as well as statistics related to patient visits; location of clinics; funding appropriations; the impact of budget challenges on under and uninsured Kansans; and the effect of the American Recovery and Reinvestment Act (ARRA) on the program (Attachment 7).

Vice-Chairperson Landwehr inquired whether it would be feasible for safety net clinics to work in conjunction with the KHPA to assist in the expansion of dental programs for pregnant women (discussed in the morning session). Ms. Harding indicated she would be meeting with Dr. Andy Allison and Barb Langner in the upcoming weeks. The topic would be added to their agenda for discussion. A report will be forwarded to Health Policy Oversight Committee members.

There was discussion related to federally funded clinics and the standards and expectations for clinics as federal funds are exhausted. In addition, non-federally funded clinics and funding to

support greater numbers of patients as fiscal shortages become greater also was discussed. Ms. Harding presented the future vision of Kansas' safety net to include a broader system of care that incorporates all partners (*e.g.*, hospitals, physicians, and public health departments) to better integrate services, to provide a system of care in some frontier areas rather than stand-alone services, and to examine methods to achieve improvement in providing needed services to Kansas citizens. To achieve the vision, a Kansas Healthcare Access Workgroup meeting will occur in late June to discuss the safety net growth plan and to consider the safety net in a larger "systems of care" perspective. Members of the Workgroup include representatives from the Kansas Hospital Association, Kansas Health Institute, Kansas Department of Health and Environment, Kansas Medical Society, Kansas Health Policy Authority, Kansas Association of Community Mental Health Centers, Kansas Department of Commerce (Rural Policy), Kansas Dental Association, Kansas Association of Local Health Departments, and the Kansas Public Health Association.

Committee members asked questions relative to presumptive eligibility for Medicaid programs and the possible use of federal stimulus HIT/HIE funds to facilitate eligibility enrollment at safety net locations. Representative Landwehr requested that Ms. Harding present her information to the KHPA Board for the purpose of raising key issues of coordination and collaboration related to the Kansas safety net.

Chairperson Barnett called upon Elaine Schwartz, Executive Director, Kansas Public Health Association, to deliver comments. Ms. Schwartz distributed written testimony (Attachment 8) in which she described the past history or "where have we been" concerning public health in Kansas. This foundation, she explained, will provide a better understanding of present and future developments of public health and public health policy in Kansas. Ms. Schwartz provided a definition of public health and why it is important; past public health achievements; essential services of public health; the importance of linking involved agencies in public health collaboration; the financing of public health initiatives; the movement toward accountability in providing public health services; and the movement toward the creation of a School of Public Health in Kansas.

Edie Snethen, Executive Director, Kansas Association of Local Health Departments, spoke regarding the current status of public health in Kansas (Attachment 9). Ms. Snethen described the work being done by local health departments related to important health issues in the state (*e.g.*, high infant mortality rate) and the importance of prevention in improved health outcomes. In addition, public health accreditation and the components involved in that process were discussed. Ms. Snethen reported on efforts to build adequate public health policy in Kansas and to provide prevention services necessary for healthcare reform. The development of a common set of expectations to clarify roles between local and state agencies, to facilitate coordination of public health services, and to interface public health services with safety net clinics and other partners was discussed as the goal of the long-range public health vision.

Dr. Jason Eberhart-Phillips, State Health Officer and Director of Health, Kansas Department of Health and Environment, spoke about the high infant mortality rate in Kansas and indicated a blue-ribbon panel has been appointed to examine this public health crisis in Kansas. He spoke about the future of healthcare in Kansas, the public health infrastructure, and the need to reduce the demand for medical care by using preventive measures (Attachment 10). Dr. Eberhart-Phillips stated that only a strengthened public health system can provide the expertise to advance this goal and that in the next thirty years, medical care costs threaten to devour one-third of the state's gross domestic product. He reported on efforts in Washington related to healthcare reform. He emphasized the importance of active public health agencies in all regions of the state to create conditions of optimal health and to manage a pandemic such as the recent H1N1 crisis. He also reviewed the long-term public health vision timeline.

Representative Landwehr asked whether it would be possible to combine services performed by public health departments and safety net clinics to reduce duplication of services and create greater efficiencies, particularly in rural or frontier areas. Dr. Eberhart-Phillips and Ms. Harding indicated that the suggestion would be considered at the Kansas Healthcare Access Workgroup meeting in late June. Senator Kelly encouraged the inclusion of other representatives (nutritionists, exercise physiologists and therapists, bike and walk enthusiasts) to the Public Health Planning Steering Committee. Senator Kelly indicated the inclusion of these representatives would be critical in the planning phase rather than during the implementation phase. Ms. Snethen indicated the suggestion would be reviewed by the Steering Committee. Senator Colyer reported that the Centers for Disease Control and Prevention funds public health in Kansas and that Kansas, with a ranking of 50th in the United States, receives nine dollars per person where other states receive more. He inquired what plans are being made to increase that amount. Ms. Snethen responded that implementing accountability and accreditation will begin to create strategies to increase federal funding for public health. Dr. Eberhart-Phillips substantiated that the federal government will reward communities who utilize a model that addresses their public health needs. Representative Ward requested Ms. Snethen provide the standards for local health department accreditation to Committee members and that Dr. Eberhart-Phillips present information regarding the management of the H1N1 pandemic in Kansas at the next meeting. Senator Barnett requested that these items be added to the next agenda.

Chairperson Barnett introduced Karen Braman and Jeff Ellis, Co-Chairpersons of the Kansas Health Information Exchange Commission. Ms. Braman distributed information regarding the short- and long-term direction for HIT/HIE in Kansas. She provided background information on the Commission's activities to develop the infrastructure needed to support health information exchange across Kansas. The Commission developed seven recommendations that were submitted to the Governor (Attachments 11 and 12) and incorporated a public-private model as the preferred way to move forward. A Health Information Security Collaborative, led by Dr. Helen Connors, was established. This statewide effort resulted in specific recommendations regarding clinical, financial, technical, privacy and security, and governance aspects of health information exchange.

Jeff Ellis stated that the recommendations were made prior to ARRA. Stakeholders throughout the state were brought together which created opportunities for Kansas to develop, monitor, and evaluate health information exchange policy. Mr. Ellis further stated that, in the HIT/HIE opportunity contained in ARRA, there are two billion dollars available for programs. Mr. Ellis encouraged that an entity be created for monitoring and coordinating an HIT/HIE process in Kansas.

Don Jordan, Secretary, Department of Social and Rehabilitation Services (SRS), appeared to discuss his role as Chairperson of the Governor's Health and Human Services (HHS) Subcabinet (Attachment 13). Governor Parkinson has assigned the HHS Subcabinet to oversee the tasks of identifying appropriate HIT/HIE projects for submission to the federal government to obtain ARRA funding. The HHS Subcabinet includes representatives from the Juvenile Justice Authority, the Departments of Corrections, Health and Environment (KDHE), SRS, and the Department on Aging. The KHPA and the Division of Information Systems and Communications also participate in the Subcabinet's activities. Secretary Jordan indicated KDHE is the lead agency in this project.

Senator Schmidt asked how the management of HIT/HIE was assigned to the HHS Subcabinet when the original plan was to assign HIT/HIE to the KHPA. Secretary Jordan indicated it was the belief that since KHPA was not a cabinet agency and with KDHE serving as the lead for day-to-day HIT/HIE activities, more resources would be available. Committee members expressed concern that the HIT/HIE recommendations made by the experts on the Commission for the Kansas Health Information Technology/Health Information Exchange Policy Initiative two years ago, would have positioned Kansas to move forward, but were never implemented. Committee members also

expressed disappointment and concern relative to the change in the assignment from KPHA to the HHS Subcabinet.

Senator Kelly pointed out that the Governor is to work through the Executive Branch to manage ARRA funds. With the involvement of the E-Health Advisory Council and the KHPA in the HHS Subcabinet activities, federal stimulus funds should be obtained for Kansas HIT/HIE projects. Representative Hill inquired whether parameters related to federal funding for these projects had been received from the federal government. Secretary Jordan indicated regular guidance is being received and the Subcabinet (with involvement from KHPA) will continue to move Kansas toward the goal of HIT/HIE project identification. Representative Hill asked for reassurance that Kansas will be in a position to compete for federal stimulus money in an expeditious manner. Secretary Jordan assured those attending that the goal of the HHS Subcabinet is to organize, coordinate, and ensure available resources are committed for the procurement of ARRA funds for HIT/HIE implementation in Kansas.

Chairperson Barnett emphasized the importance of expeditiously moving the ARRA application process forward and requested that all HHS Subcabinet outcomes and meeting minutes be furnished to Terri Weber, Legislative Research Department, for the purpose of disseminating to the members of the Joint Committee on Health Policy Oversight.

On the recommendation of Representative Bethell, the Committee agreed to send a letter to Dr. Marcia Nielsen thanking her for her service to the Kansas Health Policy Authority.

The meeting was adjourned at 3:55 p.m.

Prepared by Jan Lunn
Edited by Terri Weber and Kelly Navinsky-Wenzl

Approved by Committee on:

December 17, 2009
(Date)

HEALTH POLICY OVERSIGHT
JUNE 12, 2009

NAME	AFFILIATION
Barb Langan	KHPA
Joe Tilghman	KHPA
Elizabeth Leonard	KU Law / Health Care Acces
Alex Kotoyantz	P.I.A.
John C. Bottenberg	Bottenberg & Assoc
Matt Casey	GBA
Chad Austin	KHA
Carolyn Smith	VCHS
Mark Landwehr	Rep. Landwehr
Suzanne Wikle	KS Action for Children
David Rowe	KU Medical Center
Pat Marx	SKIL
Ami Hyten	TILRC
Barbara Belcher	Merck
Susan Zalenski	
Craig Van Aalst	KID
Gina Manee	KHI
Bob St. Peter	KHI
Steve Mock	SPS
PETER STERN	KPSC
Amanda Cole	KPSC
Connie Hubbard	KAMC
Stacy Clinton	ICAPA
Justin Meyer	KHRA
KATY BALOT	SRS
Jim Quigley	Rep. 17th
Dodie Wickshear	KAFP
Ann Marshall	Cerner

Jason Eberhart-Phillips	ICHB
Linda Orr	KDHE/OCRH
Edie Smith	KALHD
GIANFRANCO PEZZIN	K.H.I.
[illegible] Marie	ICHF
Cathy Harding	KAMU
Helen Connors	KUMC
Jeff Ellis	HIE Comm

Current as of: May 28, 2009

2009 JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT

Senate	House
Sen. Jim Barnett, Chair	Rep. Brenda Landwehr, Vice-Chair
Sen. Jeff Colyer	Rep. Bob Bethell
Sen. David Haley	Rep. Don Hill
Sen. Laura Kelly	Rep. Peggy Mast
Sen. Roger Reitz	Rep. Louis Ruiz
Sen. Vicki Schmidt	Rep. Jim Ward

Kansas Legislative Research Department

Terri Weber, Melissa Calderwood,
Kelly Navinsky-Wenzl
Other Health Policy Staff
Jan Lunn, Committee Secretary

Revisor of Statutes Office

Nobuko Folmsbee, Doug Taylor

CHARGE

The Committee has the exclusive responsibility to monitor and study the operations and decisions of the Kansas Health Policy Authority. In addition, the Committee is responsible for overseeing the implementation and operation of the children's health insurance plans, including the assessment of performance-based measurable outcomes as set out in statute.

PRELIMINARY MINUTES

JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT

March 19, 2009
Room 143-N—Statehouse

Members Present

Senator Jim Barnett, Chairman
Senator Roger Reitz
Representative Jim Ward

Staff Present

Melissa Calderwood, Legislative Research Department
Kelly Navinsky-Wenzl, Legislative Research Department
Terri Weber, Legislative Research Department
Nobuko Folmsbee, Office of the Revisor of Statutes
Doug Taylor, Office of the Revisor of Statutes
Jan Lunn, Committee Secretary

Chairman Barnett called the meeting to order at 12:15 p.m., expressing appreciation to Chad Austin and the Kansas Hospital Association for providing lunches. Chairman Barnett also welcomed all those attending.

Chairman Barnett commented that the legislation creating the Kansas Health Policy Authority (KHPA) also created the Joint Committee on Health Policy Oversight which has the exclusive responsibility to study the operations and decisions of KHPA. Chairman Barnett indicated that the legislation creating the agency provides for it to sunset on July 1, 2013; it is appropriate to examine the performance of the agency in anticipation of the legislative decision about continuation of the agency beyond its original sunset date.

Chairman Barnett reviewed the bipartisan effort in the creation of the Kansas Health Policy Authority and spoke about the role of the KHPA Board. He indicated that at the current time, the Joint Committee on Health Policy Oversight does not have processes in place to review the KHPA. Therefore, the purpose of convening this meeting is to introduce the concept and scope of a KHPA review process. Chairman Barnett called attention to three documents previously distributed to Committee members: Oversight Process (Attachment 1), Recommendations for Oversight (Attachment 2), and Targeted Review Guidelines (Attachment 3).

Chairman Barnett indicated KHPA has a number of benchmarks for tracking, and it makes sense to bring those forward regularly. In addition, resolving any ambiguity relative to expectations on the part of the Legislature and KHPA could be an initial beginning. Chairman Barnett referenced health care purchasing, coordination of aspects of Medicaid policy, quality of care issues, transparency, data coordination and implementing Health Information Technology/Health Information Exchange (HIT/HIE), as well as staff recruitment/retention in key roles, and administrative costs as possible measurement standards/goals.

Chairman Barnett asked Committee members to review performance indicators, the plan for review, and the proposed plan for reporting review results.

Senator Reitz commented that while many credible measurements exist, in his opinion, more should be done for SCHIP and covering dental services in Kansas (which is the biggest weakness in State health care). These two areas represent opportunities for measurement.

Joe Tilghman, Chairman, KHPA Board, indicated he had reviewed the draft documents, and he favorably commented on their comprehensive nature. Mr. Tilghman indicated he had three general comments related to the structure of the documents:

- He supported the draft plans containing a full role for the Governor to be engaged and involved with the Legislature relative to the oversight process, particularly for the Medicaid program.

- He supported a structured oversight process including well-documented measurement standards and expectations, particularly in light of changing environments and individuals involved.

- He supported flexibility as one of the critical success factors for modifications to any plan.

Following discussion of the three key points above, Mr. Tilghman provided a cursory review of the three documents that cite staffing, recruitment and retention as key to KHPA becoming a magnet employer; additionally, Mr. Tilghman continued, administrative costs in relation to return on investment, overall efficiencies, or both, should be evaluated rather than targeting low administrative costs as a measurement standard. In addition, "stretch goals" should be included in order to maximize performance.

Chairman Barnett indicated that as expectations are identified, input and closure from all stakeholders will occur so that goals are better defined and that measurement standards are well documented.

Dr. Andy Allison, Deputy Director, KHPA, commented on the documents in Dr. Marcia Nielsen's absence. Dr. Allison reported that Dr. Nielsen was hosting a conference and was unable to attend. Dr. Allison indicated that the KHPA leadership welcomes the oversight effort and the plan to begin early before the scheduled expiration in 2013. He indicated the task is not simple, however, the distributed plan is structured, well constructed, and provides a careful, deliberate oversight process. He reported that the KHPA Board approved a strategic plan at its meeting on Tuesday, March 17, 2009. The approved strategic plan contains goals relating to leadership in health policy and responsibility in implementing current policy. Dr. Allison indicated they will anticipate interaction in the upcoming process.

Chairman Barnett thanked all those attending and indicated another meeting would be scheduled so that the majority of Committee membership could attend and offer input.

The meeting was adjourned at 12:50 p.m.

Prepared by Jan Lunn
Edited by Terri Weber and Kelly Navinsky-Wenzl

Approved by Committee on:

_____
(Date)

Report of the Joint Committee on Health Policy Oversight to the 2009 Kansas Legislature

CHAIRPERSON: Representative Melvin Neufeld

VICE-CHAIRPERSON: Senator Jim Barnett

OTHER MEMBERS: Senators David Haley, Laura Kelly, Roger Reitz, Vicki Schmidt, and Susan Wagle; and Representatives Bob Bethell, Jeff Colyer, Bill Feuerborn, Brenda Landwehr, and Louis Ruiz.

STUDY TOPIC

The Committee has the exclusive responsibility to monitor and study the operations and decisions of the Kansas Health Policy Authority. In addition, the Committee is responsible for overseeing the implementation and operation of the children's health insurance plans, including the assessment of performance-based measurable outcomes as set out in statute.

LCC REFERRED TOPICS

Premium Assistance. Study the premium assistance legislation that was proposed by the Kansas Health Policy Authority to the 2008 Legislature. Review the impact of such a proposed premium assistance program and the short-term and long-term fiscal impact of such a program.

June 2009

Joint Committee on Health Policy Oversight

Report

Conclusions and Recommendations

- That it is important for the Kansas Health Policy Authority to keep an open mind to all health reform opportunities and to continue to look beyond premium assistance to identify alternative ways to provide improved health services. As part of these efforts, the Health Policy Authority should make an objective analysis of what safety net clinics provide and whether safety net clinics are keeping patients out of the emergency room;

- Concerning the placement of mental health drugs on the Preferred Drug List, the Committee noted that it will be important to have an automated Prior Authorization (PA) system in place for use by pharmacists to avoid delay or complications in getting a prescription covered through the Medicaid system; and

- Concerning the performance data collected by the Kansas Health Policy Authority on HealthWave services providers, the Committee expressed concern that the data is not shared with providers or used for improvement of services. The Committee further expressed concern about allowing members to change from one plan to another on a monthly basis, which can be disruptive to providers. The Committee requested that the Health Policy Authority provide a performance report on HealthWave service providers, including pharmacy claims, to the Oversight Committee and continue its efforts with the Centers for Medicaid and Medicare Services to find a way to design the enrollment stage to eliminate plan switching as much as possible.

The Oversight Committee made the following recommendation:

- That the Kansas Health Policy Authority enter into dialogue with the HealthMapRx/Asheville Project to conduct a pilot project in a specified geographic area of Kansas. Dialogue concerning the pilot project should include targeting the diabetes population and addressing the possibility of a delayed payment arrangement for services provided by HealthMapRx. Consideration should be given to using realized cost savings from the pilot project as the basis for the payment arrangement.

The Oversight Committee also acknowledged agency efforts in the following areas:

- An acknowledgment of the work of the Kansas Health Policy Authority and the Kansas Insurance Department in conducting the bariatric surgery study; and

- An acknowledgment of the work of the Kansas Health Policy Authority with regard to the issue of data quality and a request that the Health Policy Authority return to the Legislature as soon as possible with information on how to proceed with the collection and utilization of health-related data in setting data-driven health policy.

Background

The Joint Committee on Health Policy Oversight operates pursuant to KSA 46-3501, et seq. The Committee was created by the 2005 legislation that also established the Kansas Health Policy Authority and transferred certain health-related functions to the new agency. The Committee is composed of 12 members, six from the Senate and six from the House of Representatives. Each member serves a two-year term ending on the first day of the regular legislative session commencing in odd-numbered years. The Oversight Committee is authorized to introduce legislation.

The Oversight Committee is charged with monitoring and studying the operations and decisions of the Kansas Health Policy Authority (KHPA). The Health Policy Authority is charged by law with improving the health of the people of Kansas by increasing the quality, efficiency, and effectiveness of health services and public health programs. Additionally, as part of the 2008 House Substitute for Senate Bill 81, the Oversight Committee is charged with the responsibility to oversee the implementation and operation of the state's children's health insurance plans, including the assessment of the performance based measurable outcomes as set out in subsection (b)(4) of KSA 38-2001. The legislation creating the Oversight Committee expires on July 1, 2013.

The Oversight Committee also received a request from the Legislative Coordinating Council (LCC) to study the premium assistance legislation that was proposed by the Kansas Health Policy Authority to the 2008 Legislature. The LCC requested that the Oversight Committee review the short-term and long-term fiscal impact of the proposed premium assistance legislation.

Committee Activities

During the 2008 Interim, the Oversight Committee held a one-day meeting on August 14 and a two-day meeting on November 20 and 21. The Committee heard testimony and deliberated on the following topics and issues as presented by the Kansas Health Policy Authority, other state agencies, and representatives of various health-related programs.

Overview of Kansas Health Policy Authority Accomplishments

Joe Tilghman, Chairman, KHPA, presented an overview of the accomplishments of the Authority during the prior year to improve the health of Kansans including:

Medicaid/Health Wave

- Reformed Disproportionate Share Hospital (DSH) reimbursement which will provide at least $26.5 million in federal matching funds annually for treating indigent patients;

- Increased efficiencies by using standardized medical identification cards. Kansas is the first state to make card information conform with national advanced ID card technology standards;

- Expanded dental care to pregnant mothers and offered preventive and restorative care. Electronic billing for dental services increased to 80 percent as more dentists took advantage of online billing;

- Increased enrollment in the Working Health Program which allows people with disabilities who are working, or interested in working, the opportunity to maintain Medicaid coverage while on the job;

- Increased administrative efficiencies through document imaging technology that manages

documents and makes them more portable and accessible to users; and

- Complied with new state and federal provider identification requirements for the submission of all pharmacy claims.

State Employee Health Plan (SEHP)

- Increased the employer contribution rate for dependent coverage from 45 to 55 percent;

- Provided a broad range of wellness programs for state employees. Approximately 16,300 members took advantage of the personal health assessment and over 9,000 individuals participated in health screening events;

- Implemented the CareEntrust program, a health information exchange pilot program; and

- Received recognition from the national Institute for Health and Productivity Management for innovative strategies in the 2009 State Employee Health Plan which were designed to control costs and promote healthy lifestyles.

Statewide Initiatives

- Completed plans to implement data analysis infrastructure by Fall 2009;

- Launched an online Health Consumer search tool in January 2008 to assist consumers by empowering them with resources to stay healthy;

- Began to operationalize the Medical Home Model by convening a stakeholder group that includes providers, consumers, and health plan and business representatives with the goal to create a medical home model for Kansas that includes incentives for payment reform;

- Implemented the E-Health Advisory Council to explore options to leverage the state's purchasing power to promote the use of health information technology and to provide recommendations on policy issues related to health information technology; and

- Was selected, along with eight other states, to participate in the State Quality Improvement Institute designed to help states develop and implement substantive action plans to improve performance across targeted quality indicators.

Review of 2008 Health Reform Legislation and 2009 Health Reform Recommendations

Dr. Marcia Nielsen, Executive Director, KHPA, presented a review of the objectives and mission of KHPA; identified problems in the health and health care system in Kansas; reviewed the health reform recommendations submitted by the KHPA Board to the Governor and to the 2008 Legislature; and discussed the next steps proposed by KHPA in improving the health of Kansans.

2008 Health Reform Legislation. Dr. Nielsen stated that nine of the KHPA's original 21 health reform recommendations were passed by the Legislature including the health care cost and quality transparency project; a statutory definition of "medical home"; insurance form standardization; partnering with public health community organizations; adding the Education Commissioner as an *ex-officio* member of the KHPA Board; collecting fitness data in schools; promoting healthy foods in schools; promoting fitness in schools; and tobacco cessation programs for pregnant women receiving Medicaid benefits. Also, there were several unfunded mandates (Staff note: five unfunded mandates) in House Substitute for SB 81 including Medicaid provider reimbursement; statewide community health records initiative; healthier food for state

employees; dental care for pregnant women receiving Medicaid benefits; and aggressive outreach and enrollment of children eligible children for Medicaid/State Children's Health Insurance Program (SCHIP) services.

Dr. Nielsen stated that the seven reform recommendations that did not pass included health literacy; an increased tobacco user fee; a statewide smoking ban; a grant program for small business wellness initiatives; expanded cancer screenings; premium assistance for low income adults without children; and small business initiatives.

Dr. Nielsen indicated that it was the intention of the KHPA to implement the unfunded reform mandates starting January 1, 2009, before the funds were actually appropriated, if the Oversight Committee was supportive of the action. Also, Dr. Nielsen indicated that it might be wise to delay expansion of the State Children's Health Insurance Program until additional federal funding became available.

In response, the Committee stated that it was the intention of the 2008 Legislature that these mandates not be implemented until July 1, 2009, allowing the full Legislature ample time to review the mandates before actual implementation and appropriation of funding.

2009 Health Reform Recommendations. At the November Committee meeting, Dr. Nielsen noted that budget shortfalls within the state would impact how KHPA proceeded with the 2009 Health Reform Recommendations. She also noted that KHPA had implemented budget reductions to comply with budget cuts as requested by the Division of the Budget and that no supplemental funding was included in the agency budget request, as discussed at the August Committee meeting.

Dr. Nielsen stated that the KHPA's 2009 Health Reform Recommendations include:

- Implementing a statewide clean indoor air law to save lives and health care costs;
- Increasing tobacco user fees to generate approximately $87.4 million in new revenue to be used to expand health care coverage for low-income individuals, young adults, and small businesses;
- Increasing access to affordable health care and prevention for small businesses and young adults;
- Continuing the 2008 Health Reform Recommendation to facilitate a statewide community health record information and exchange system to improve efficiency and promote cost savings;
- Continuing the 2008 Health Reform Recommendation to expand early detection cancer screenings;
- Continuing the 2008 Health Reform Recommendation to coordinate school health and workplace wellness for small businesses;
- Continuing the 2008 Health Reform Recommendation to improve tobacco cessation in Medicaid; and
- Continuing the 2008 Health Reform Recommendation to improve outcomes and promote cost effectiveness by investing in long-term health reform and Medicaid transformation goals.

Update on Current Kansas Health Policy Authority Programs

Representatives of the Health Policy Authority provided updates on the following KHPA programs.

Medicaid Transformation Plan. Dr. Andy Allison, Deputy Director, KHPA, noted

that Medicaid spending in FY 2009 would be approximately $2.5 billion (All Funds, all agencies) and that it is anticipated that Medicaid will grow by 5.5 percent in FY 2009 – a combination of growth and cost in the plan. Dr. Allison provided an overview of the Medicaid Transformation Process stating that a comprehensive review of the various Medicaid programs began in 2007 and includes 14 overlapping program areas grouped into four broad categories - health care services and programs, populations, eligibility, and quality improvement. The program reviews will be ongoing with the review recommendations to be used for budget, administrative, and revenue dependent initiatives; to identify areas requiring further study; and for policy development.

Dr. Allison presented a summary of the Medicaid Transformation Process recommendations for 2008 including the following five-year projected savings:

- Budget initiatives savings of $11.7 million in pharmacy management, public insurance outreach initiatives, and quality review of fee-for-service programs; and

- Administration initiatives savings of $16.6 million.

The 2009 Medicaid program review topics will include the KHPA Medicaid operations, Medicaid mental health services, and Medicaid funding of safety net clinics.

Medical Home Health Care Delivery Model. Dr. Terry Lee Mills, President, Kansas Academy of Family Physicians, provided testimony on the Medical Home Delivery Model. Dr. Mills noted that primary care is foundational for the effective and efficient functioning of the health care delivery system and primary care physicians are the point of first contact for many patients. Responding to questions from the Committee, Dr. Mills stated that adequate accessibility to physicians must be available to make the system efficient. The Committee questioned how funds will be available to secure the services of health care providers. Dr. Mills indicated that it is important to improve the quality of health care in the beginning in order to produce cost savings by not using the emergency room. With regard to mental health providers, Dr. Mills noted that, as part of the medical home concept, service providers are required to provide mental health services either through doctors in the practice or through contractual arrangements with other service providers. Dr. Mills stated that there are approximately ten or fewer practices certified as medical homes at the present time.

Community Health Record Pilot Projects. Dr. Barbara Langner, Policy Director, KHPA, updated the Committee on two pilot community health record (CHR) projects in the state. She stated that a CHR for a patient crosses the traditional health system boundaries so that various health care providers are better informed and can provide timely service. The data found in a CHR includes patient demographics, a history of medical visits, known allergies and medications, immunizations, treatment results, and the extent of health benefit coverage.

The first pilot project is located in Sedgwick County and is focused on the Medicaid Managed Care population. The project started in February 2006 with 20 sites. In May 2008, an expansion of up to 20 additional sites was started and will include mental health facilities, emergency departments, family care centers, pediatric care centers, home health agencies, safety net clinics, federally qualified health centers, and specialty clinics.

The second pilot project is located in Kansas City and was started in May 2008. The project is administered by CareEntrust Health Exchange, a non-profit organization that includes 24 of the metropolitan area's larger employers and health care organizations, including the State Employee Health Plan. CareEntrust aggregates information from health plans, pharmacy benefit managers,

laboratories, and immunization registry data and stores it centrally where it is accessible to health care providers.

Dr. Langner noted that KHPA plans to expand the pilot projects to more counties across the state.

State Employee Health Plan. Doug Farmer, Director of the State Employee Health Plan, KHPA, reported on the status of the State Employee Health Plan for the current Plan Year (PY) 2008 and the potential changes for PY 2009. Mr. Farmer stated that there are approximately 93,000 people covered by the SEHP of which 73.4 percent are state employees and dependents, 13.0 percent are non-state employees, 12.3 percent are retirees, and 0.3 percent are covered under the federal COBRA insurance requirements. PY 2008 is the first year that the SEHP is self-insured with the Plan assuming the financial risk for all covered lives. For PY 2008, medical coverage is purchased through Blue Cross Blue Shield of Kansas, Preferred Health Systems, and Coventry. Dental coverage is purchased through Delta Dental, and vision coverage is purchased through Superior Vision. Prescription drugs are purchased through Caremark.

The state's employer contribution is equal to approximately 95.0 percent of the costs associated with a single member's coverage. For a member with dependents, the state contributes approximately 55.0 percent of the cost, and the employee covers the remaining 45.0 percent. The Health Policy Authority listed various alternatives that may be considered for incorporation in PY 2009 to provide the optimal benefit for individual members and to meet their health care needs.

Mr. Farmer noted that House Sub for SB 81, in part, encourages state employees to utilize the qualified high deductible health plan offered by the state. The bill requires that any cost savings due to an employee's election of the high deductible plan be added to the state's employer contribution. The Director explained that regardless of which health plan a full-time state employee selects, the state's employer contribution is the same amount ($401.06). The Health Policy Authority believes that the provisions of House Sub for SB 81 are already being met and no further actions are necessary.

Data Consortium. Dr. Hareesh Mavoori, Director of Data Policy and Evaluation, KHPA, presented testimony on the Data Consortium. Dr. Mavoori stated that the Data Consortium, chartered by the KHPA Board in April 2006, has been directed to leverage Kansas health data to advance health reform via data-driven policy. Specifically, the formation of the Data Consortium is to:

- Guide KHPA in the management of programmatic and non-programmatic health data;
- Ensure continued public support and investment in the use of this data to advance health policy;
- Disseminate the data, in partnership with stakeholders; and
- Ask and answer important health policy questions pertaining to the access, affordability, and quality of health care and health status of Kansans.

Dr. Mavoori provided a listing of data measures recommended by the Data Consortium grouped into four major categories: access to care; health and wellness; quality and efficiency; and affordability and sustainability. The data will be classified into different tiers of information with Tier 1 including data such as vital statistics records and Medicaid records, Tier 2 including information such as Kansas Insurance Department records that have not been checked for integrity, and Tier 3 including data such as full-time equivalency (FTE) of health care providers and workers that is not currently

collected. Dr. Mavoori indicated that the results of a data comparison with other states will be available by the end of January 2009 and that the data provided by the Consortium will provide consumers with readily available information, allow for comparison, and encourage patient safety. Implementation of the data interface is to be "up and running" by the end of 2009.

Chronic Care Management. Dr. Nielsen reviewed the on-going chronic care management initiatives of the KHPA that include:

- A $900,000 Centers for Medicare and Medicaid Services (CMS) health promotion grant for the disabled;
- The Enhanced Care Management pilot project in Wichita; and
- The State Employee Health Plan's HealthQuest Program.

In January 2008, Kansas was awarded $900,000 to improve preventive health for disabled Kansans enrolled in Medicaid. The grant is part of the $150 million approved by Congress for Medicaid Transformation Grants. These funds are to be used primarily for case management, specifically case managers. Dr. Nielsen noted that an enhancement of $250,050 from the State General Fund will be requested for FY 2010 because the federal grant does not fully fund the pilot project. Initially, approximately 1,700 disabled Kansans are to be served and the Authority proposes to expand the program to cover all eligible aged and disabled persons across the state.

The Enhanced Care Management Project is designed to provide care management services to HealthConnect beneficiaries living in Sedgwick County. The project connects providers and beneficiaries through existing community resources. The project team includes a nurse, a social resources manager, and a physician. Consumers are Medicaid beneficiaries with chronic health conditions that have an increased probability for high-risk medical expenditures. As of February 2008, the pilot project had 194 actively enrolled beneficiaries. The Oversight Committee expressed concern about the effectiveness of the program and a need to see the actual cost savings of the project. The Committee also expressed concern that no pharmacists were included on the pilot project team.

Dr. Nielsen further explained the components of the HealthQuest Program that is available to members of the State Employee Health Plan. HealthQuest is administered on behalf of the state by Health Dialog through a three-year contract. Participants can access online programs and tools through the Dialog Center and HealthMedia. Approximately 16,300 participants have taken advantage of the online personal assessment program and over 9,000 individuals participated in the health wellness program. As a follow-up to these programs, HealthDialog made phone calls and mailings to participants to determine what health coaching assistance they needed. The Oversight Committee observed that there is a need to address the barriers to health care.

Additional Kansas Health Policy Authority Studies (LCC Topics)

The Oversight Committee heard testimony on the status of studies requested by the Legislative Coordinating Council for the 2008 Interim. KHPA organized the nineteen requested studies into the following major topic areas:

Medicaid. Eight studies were requested covering the topics of allowing the Inspector General to keep a portion of the moneys recovered from persons committing Medicaid fraud; encouraging wellness, efficiency, and aligning payment policies with Medicare payment policies; allowing Medical Assistance recipients whose assistance has ceased to purchase coverage for up to three years; studying the experiences of other states in reforming Medicaid; studying long-term care in Medicaid reform; studying waste, fraud,

and abuse in Medicaid reform; studying Health Opportunity Accounts in Medicaid reform; and studying other Medicaid reforms allowed by federal law.

State Employee Health Plan. A study was requested concerning the impact of a requirement which would allow the employer contribution to any Health Savings Account (HSA) plan offered to state employees to be equal to the employer contribution to any other state health plan offered to state employees.

Health Insurance. Six studies were requested covering the topics of using individual and small business tax credits to expand affordable commercial insurance; encouraging Health Savings Accounts, High Deductible Health Plans, and Section 125 Plans as a means to expand affordable commercial insurance; allowing insurers to provide incentives in return for participation in programs promoting wellness, health, and disease prevention to expand affordable commercial insurance; allowing insurers to offer young adult policies with limited benefits and reduced premiums to expand affordable commercial insurance; studying changes to the plans of the Kansas Health Insurance Association, including eligibility and the use of reinsurance mechanisms to expand affordable commercial insurance; and studying small business health policies including the creation of a Small Business Health Policy Committee, allowing very small employers to obtain health insurance and making health insurance more affordable for small businesses and employees to expand affordable commercial insurance.

Other Health Care Issues. Four studies were requested covering the topics of the health workforce supply; physical fitness in schools; transparency health; and a statutory committee on health futures.

Dr. Nielsen stated that the Legislative Coordinating Council requested KHPA to produce the study results by November 1, 2008. If approved by the KHPA Board, Dr. Nielsen requested that the deadline of some of the reports be extended. The Oversight Committee took action to authorize the Committee Chairman, upon notification of the Board's approval of the KHPA staff request, to send a letter to the LCC requesting an extension of the report deadlines to the first day of the 2009 Legislative Session. Notification of Board approval was received, a Committee letter was sent, and LCC approval was received in October 2008 to extend the report deadlines to January 2009.

Study of High Risk Pool (LCC Topic)

Bruce Witt, Vice-President, Kansas Health Insurance Association (KHIA), presented testimony on a study requested by the Legislative Coordinating Council for the 2008 Interim to allow the Administrating Carrier of the High Risk Pool (HRP) to offer coverage in the Pool through Section 125 cafeteria plans which may include a High Deductible Health Plan (HDHP) and the establishment of a Health Savings Account (HSA). Additionally, KHIA was to study expanding participation in the Pool by subsidizing premiums, including accessing federal grants and programs.

Mr. Witt stated that KHIA was created by the Kansas Legislature in 1992 to provide insurance for people with health conditions that make it difficult for them to obtain health coverage and who are not eligible for Medicare or Medicaid. Kansas is one of 35 states that have established HRPs. At the end of 2007, there were an estimated 201,000 enrollees across the U.S., with approximately 1,907 enrollees in the KHIA program. Coverage requires proof of Kansas residency for the prior six months, ineligibility for Medicare or Medicaid, and involuntary termination of health insurance coverage for reasons other than nonpayment of premiums. Mr. Witt indicated that the average premium for participants in the Pool is approximately 130 percent over the standard premium rate.

Mr. Witt reported the results of KHIA's study as follows:

- The Section 125 option currently does not apply to KHIA in that the Association only offers individual policies with no employer/ employee relationship. Legislation would be needed for employer groups to be brought into KHIA and the fiscal impact of such a move would need to be assessed;

- KHIA currently offers several HDHPs, one of which is HSA compliant for individuals; and

- KHIA could be used as a vehicle to broaden coverage for uninsured Kansans but given the losses incurred by current enrollees, state subsidization or other external funds would be needed to ensure adequate claims reserves, ongoing fiscal viability and administrative capacity. Legislation and additional, sustainable funding would be required.

Review of 2008 Premium Assistance Legislation (LCC Topic)

As requested by the Legislative Coordinating Council (LCC), the Oversight Committee reviewed the premium assistance legislation that was proposed by the Health Policy Authority to the 2008 Legislature. Dr. Nielsen provided an overview of the research conducted before the issue was brought to the Legislature and stated that, because of the considerable research done prior to the 2008 Session and because no additional funding had been provided, the Authority did not pursue further research or analysis of the subject. In response to Dr. Nielsen's request for direction from the Committee regarding further study, the Committee indicated that, because of current budget constraints, it felt that the appropriate action would be to maintain the current program and to not add any enhancements at this time.

Study of Bariatric Surgery for the Morbidly Obese (2008 HB 2672)

Dr. Andy Allison presented an overview of the study on coverage for bariatric surgery required by 2008 HB 2672 which provided that KHPA, in collaboration with the Kansas Insurance Department, study and make recommendations for the potential state coverage of bariatric surgery in the State Employee Health Plan and the affordability of such coverage in the public and private sectors. Dr. Allison stated that the Health Care Commission (HCC) began considering coverage for bariatric surgery in 2006, and KHPA engaged in a statewide health reform initiative in 2007. In 2008, the HCC decided to cover preventive and non-invasive obesity treatments under the SEHP. The coverage in 2008 covered non-surgical treatment of obesity, expanded coverage for consultation with a dietitian and added coverage for prescription weight loss medications. Kansas now has four Centers of Excellence for bariatric surgery as designated by the American Society for Bariatric Surgery. Additionally, Medicare covers bariatric surgery for all beneficiaries and research evidence shows the positive health impact of bariatric surgery for the extremely obese.

Dr. Allison stated that the estimated cost of coverage for bariatric surgery in the SEHP would be as much as $15 million in the first year and would depend on the required pre-conditions. There could be additional costs of coverage in the Medicaid program. However, there would be a long-run net savings to the state.

The KHPA recommendations included:

- Emphasizing the value of preventive care which has already begun in the SEHP and which is being developed for the Medicaid program; and

- Developing recommendations to present to the HCC to cover bariatric surgery in the SEHP by using Medicare coverage as

a starting point, by working with weight loss and surgical experts to target surgery to those who can benefit most and considering Medicaid coverage if funding is available.

Linda Sheppard, Director, Accident and Health Division, Kansas Insurance Department, presented testimony on the impact of extending coverage for bariatric surgery in the Small Business Employer Group and High Risk Pool. Ms. Sheppard noted that the Kansas Insurance Department conducted a survey of the 25 insurers licensed to sell small group coverage in Kansas, to determine the affordability of coverage in the small group market. The 13 insurers who responded to the survey were reluctant to provide a definitive response because of the absence of specific information regarding the amount and type of benefits to be provided and the criteria to be used to determine the medical necessity for bariatric surgery. However, the insurers estimated an impact on premiums in the small group market to be in the range of approximately one to eight percent, with an average of approximately three percent. They estimated an average benefit payment of $16,000. The actual amount billed by the providers was in excess of $6.5 million, with an average billed amount of $45,000 per procedure.

The Kansas Insurance Department also requested and reviewed historical costs and benefits data for the KHIA High Risk Pool policy. Treatment of obesity is excluded from coverage under the KHIA policy. However, it has been provided to members when treatment is determined to be medically necessary by KHIA's utilization review organization. From January 1, 2006, through September 30, 2008, KHIA paid benefits for bariatric surgery, including both gastric bypass and gastric banding, for nine members at a total cost of approximately $96,000. KHIA's consulting actuary reported that there has been no significant impact on member premiums over the past four plan years covering the nine surgery procedures. However, changes in the criteria and documentation currently used could have a significant impact on KHIA's costs if greater numbers of procedures were approved and performed.

Annual Report - State Children's Health Insurance Plans

As part of 2008 House Sub for Senate Bill 81, the Oversight Committee was charged with the responsibility to oversee the implementation and operation of the state's children's health insurance plans. Dr. Allison presented the annual update on the children's health insurance plans that include physical health plans, mental health and substance abuse plans, and fee-for-service dental care.

Dr. Allison noted that the insurance plans are administered through HealthWave, the state's program of managed care providing medical services to children and families eligible for Medicaid (Title XIX of the Social Security Act) and the State Children's Health Insurance Plan (SCHIP) (Title XXI of the Social Security Act). HealthWave was created in January 1999 for the SCHIP population and then expanded to include Medicaid managed care members. To be eligible for HealthWave, the total countable income must not exceed the monthly federal poverty level standards based on the appropriate number of family members. Quality of care is measured by using the nationally recognized Healthcare Effectiveness Data Information Set, satisfaction surveys, and performance improvement projects. Dr. Allison stated that the Health Policy Authority routinely monitors the quality and operational performance of all plans.

Eligible children receive their medical coverage through either UniCare Health Plan of Kansas or Children's Mercy Family Health Partners. The Oversight Committee heard testimony from representatives of both plans explaining their coverage activities over the past year. UniCare currently serves approximately

51,000 members, and Children's Mercy serves approximately 111,000 children.

The behavioral health benefits for eligible children are managed by Cenpatico Behavioral Health Systems. The Committee heard testimony from a representative of Cenpatico who reported that over 40,000 members are currently served. The Cenpatico representative also noted that it is difficult to determine an appropriate way to share quality outcomes with providers.

The Project Manager for HealthWave's Clearinghouse, who also is a representative of MAXIMUS, provided testimony on the HealthWave Project which MAXIMUS operates under contract with the Health Policy Authority. MAXIMUS was awarded its original contract competitively in August 1998 to provide health care to children. The current scope of work includes:

- Determining new eligibility for Title XXI (SCHIP);
- Completing yearly reviews for Title XXI customers;
- Providing screening and ancillary work for Title XIX customers;
- Completing requested changes on open clearinghouse cases;
- Verifying citizenship and identity for Title XIX applicants;
- Providing both live and voice mail customer service assistance via a toll-free line; and
- Collecting and administrating premium payments for Title XXI customers.

The MAXIMUS representative further noted that, during the past few years, MAXIMUS has converted case files and other information into digital image files to allow for greater transparency and access to information. Maximus also has made changes to accommodate the new federal requirement to verify citizenship and identity of Medicaid recipients. Currently, applications and reviews are processed in less than 30 days with most processed in seven to ten days.

The Oversight Committee expressed a concern that while performance data is collected, it is not shared with providers or used for improvement. The Committee requested that the Health Policy Authority provide a performance report on pharmacy claims. The Oversight Committee further expressed concern about allowing members to change from one plan to another on a monthly basis, which could be disruptive to the providers.

Dr. Allison stated that the Health Policy Authority is aware of the problem and that approximately 40.0 percent of members initially do not specify a health plan choice and are auto-enrolled in a health plan. He further stated that the Health Policy Authority is working with the Centers for Medicaid and Medicare Services to find a way to design the enrollment stage to eliminate most of the switching. Dr. Allison concluded by stating that the Health Policy Authority believes it has a firm base and effective partnership to operate HealthWave across the state. Data is being used to make health care decisions and the Authority is committed to making the program stronger by sharing reviews publicly and holding contractors accountable.

Other Topics and Issues

The Oversight Committee also heard testimony on the following topics and issues.

HealthMapRX/Asheville Project. The Oversight Committee heard testimony at both interim meetings about the American Pharmacists Association Foundation's Asheville Project. At the August 14 meeting, legislative staff from the Kansas Legislative Research Department presented an overview of the Asheville Project.

The Asheville Project is a voluntary, enhanced pharmaceutical care services program that began in 1998 in Asheville, North Carolina, and is designed to combat the effects of chronic diseases on the workforce. The mission is to improve the quality of consumer health outcomes. The program focuses on four chronic diseases – diabetes, cardiovascular health and hypertension, asthma, and depression. The model centers on the patient and includes collaboration among all stakeholders – patients, employers, pharmacists, physicians, hospitals, other health care providers, and health educators. The long-term outcomes include a decrease in direct medical costs for the patient.

At the November meeting, a consultant to the American Pharmacists Association, presented the Committee with more details about the HealthMapRx/Asheville Project. Initially the program focused on persons with diabetes. Since then it has grown to include asthma, lipids, hypertension, and depression. Physicians with patients in the program see their patients more often than before, but costs are reduced due to preventive care versus actual care needs. Asheville has had four consecutive years of a below zero increase in the cost of health care. The concept of HealthMapRx is to drive down health costs by promoting preventive care. The program provides the tools for members to maintain better health and holds members accountable for their health.

A representative from the American Pharmacists Association Foundation stated that should Kansas decide to create a pilot program, the Foundation would provide assistance to the state in developing a profile, in selecting a patient population in a geographic area, and in identifying a local health care provider network. The American Pharmacists Association Foundation has found that 80 percent of sites that have adopted programs similar to Asheville's will see a reduction of costs in the first year and an increase in quality of life. The Oversight Committee expressed concern about up-front costs. The Committee later suggested that perhaps initial costs could be reimbursed at a later time from the accrued savings attributable to a pilot project.

Wy/Jo Care Program. A representative of the Medical Society of Johnson and Wyandotte Counties Foundation presented an overview of the Wy/Jo Care Program to the Oversight Committee at its November meeting. The Wy/Jo Care Program's mission is to enhance access to health care and improve the health status of the low-income, uninsured residents of Johnson and Wyandotte Counties by partnering with safety net clinics to connect their patients with donated medical services. Physicians lead the program, and currently, over 200 physicians are involved in the program. At this time, there are eight clinics in Wyandotte and Johnson counties that participate in the program. Blue Cross Blue Shield of Kansas City works with the program to record the amount and cost of charitable health care. Wy/Jo Care plans to expand into other areas, including dental care for pregnant women and physical therapy. Prior to receiving care, patients sign a form that indicates that they are receiving charitable care. Physicians are covered by the Kansas Tort Claims Act when providing charitable care. Since Wy/Jo Care's creation in 2006, no tort claims have been filed.

Update on Wichita Center for Graduate Medical Education (WCGME) Funding. Representative Landwehr updated the Committee members on the activities of the Physician Workforce and Accreditation Task Force. She stated that the Task Force is charged with determining how best to maintain accreditation of the graduate medical education programs sponsored by the University of Kansas School of Medicine, in particular, the WCGME program. The Task Force also is charged with making funding recommendations for the programs. Representative Landwehr noted that the Task Force is reviewing the physician workforce throughout Kansas.

Penny Vogelsang, Chief Operating Officer, WCGME, presented an update on the funding request to the Kansas Bioscience Authority (KBA) for the WCGME Research Enhancement Initiative. The proposal to KBA includes the development of a collaborative organization and infrastructure to support clinical and translational research that would: increase the number of resident physicians with research training or experience with the potential to translate research discoveries into practice and into the marketplace; enhance existing clinical and translational research programs of the faculty including opportunities for commercialization of the findings; enhance research partnerships with other educational and clinical institutions in the area and throughout Kansas; and increase collaboration with the commercial life sciences community in the region and throughout the state.

Ms. Vogelsang noted that, in a proviso, the 2008 Legislature included $1.5 million from the State General Fund for FY 2009 with the provision that WCGME seek $7.1 million in funding from the KBA for a research-oriented grant. Ms. Vogelsang stated that it will be difficult to get a commitment from research staff and to make research sustainable because multiple-year funding was not authorized. There also is a concern because of the current budget shortfall within the state.

Jim Mitchell, Director, Heartland BioVentures and Investments, KBA, indicated that it is not the intent of the KBA to duplicate research being done in other environments, but to expand and develop outcomes in new areas. Dr. Mitchell noted that it was difficult in the beginning to tie the WCGME research proposal into the work of the KBA. To meet accreditation requirements, basic research needed to be established at WCGME. However, the research needed to tie into what the KBA could support from a funding aspect because of the charter established by the Legislature for the KBA. The research also needed to be fully required by the accreditation process.

Conclusions and Recommendations

Based on the testimony heard and Committee deliberations, the Joint Committee on Health Policy Oversight reached the following conclusions:

- That it is important for the Kansas Health Policy Authority to keep an open mind to all health reform opportunities and to continue to look beyond premium assistance to identify alternative ways to provide improved health services. As part of these efforts, the Health Policy Authority should make an objective analysis of what safety net clinics provide and whether safety net clinics are keeping patients out of the emergency room;

- Concerning the placement of mental health drugs on the Preferred Drug List, the Committee noted that it will be important to have an automated Prior Authorization (PA) system in place for use by pharmacists to avoid delay or complications in getting a prescription covered through the Medicaid system; and

- Concerning the performance data collected by the Kansas Health Policy Authority on HealthWave services providers, the Committee expressed concern that the data is not shared with providers or used for improvement of services. The Committee further expressed concern about allowing members to change from one plan to another on a monthly basis, which can be disruptive to providers. The Committee requested that the Health Policy Authority provide a performance report on HealthWave service providers, including pharmacy claims, to the Oversight Committee and continue its efforts with the Centers for Medicaid and

Medicare Services to find a way to design the enrollment stage to eliminate plan switching as much as possible.

The Oversight Committee made the following recommendation:

- That the Kansas Health Policy Authority enter into dialogue with the HealthMapRx/ Asheville Project to conduct a pilot project in a specified geographic area of Kansas. Dialogue concerning the pilot project should include targeting the diabetes population and addressing the possibility of a delayed payment arrangement for services provided by HealthMapRx. Consideration should be given to using realized cost savings from the pilot project as the basis for the payment arrangement.

The Oversight Committee also acknowledged agency efforts in the following areas:

- An acknowledgment of the work of the Kansas Health Policy Authority and the Kansas Insurance Department in conducting the bariatric surgery study; and

- An acknowledgment of the work of the Kansas Health Policy Authority with regard to the issue of data quality and a request that the Health Policy Authority return to the Legislature as soon as possible with information on how to proceed with the collection and utilization of health-related data in setting data-driven health policy.

STATE OF KANSAS

JIM BARNETT
SENATOR, 17TH DISTRICT
CHASE, COFFEY, GREENWOOD
LYON, MARION, MORRIS, AND OSAGE
COUNTIES

TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS
CHAIR: PUBLIC HEALTH AND WELFARE
CHAIR: KANSAS HEALTH POLICY OVERSIGHT COMMITTEE
MEMBER: AGRICULTURE
FINANCIAL INSTITUTIONS AND INSURANCE
ORGANIZATION, CALENDAR AND RULES

DRAFT

June 12, 2009

Dr. Marcia J. Nielsen, Care of The Kansas Health Policy Authority
900 North, Landon State Office Building
900 SW Jackson Street
Topeka, KS 66612

Dear Dr. Nielsen:

On behalf of the current and prior members of the Joint Committee on Health Policy Oversight, I would like to take this opportunity to thank you for the leadership and dedication you have provided to the State of Kansas as the first Chairperson of the Kansas Health Policy Authority Board and as the Executive Director of the Kansas Health Policy Authority. When the Kansas Health Policy Authority was created in July 2005, it was given the broad charge of developing a coordinated statewide health policy agenda that combines effective purchasing and administration of health care with public health strategies that promote the overall health of all Kansans.

As Chairperson of the Kansas Health Policy Authority Board and then as Executive Director of the Authority, you set out an aggressive agenda that included all stakeholders in a process that would impact how the State views health and health care. During your tenure, the Authority Board was established and its role in leading the agency was defined. A vision for a more healthy Kansas was clarified and priorities were identified to meet the Authority's charge.

In addition to overseeing the statutorily required transfer and internal reorganization of major state health services, the Health Policy Authority began numerous initiatives in meeting its charge to develop a coordinated statewide health policy agenda. Some of these ongoing initiatives include providing health and health care information to the general public; identifying available and needed data sources to set sound data-driven health policy; coordinating and encouraging the implementation of health information technology throughout the state; and assessing and addressing policy issues in each major program area within Medicaid. The work of many of these initiatives has been accomplished through the volunteered efforts and input of stakeholder advisory groups and by openly sharing data and information as it becomes available.

The Kansas Health Policy Authority has established working relationships with numerous federal agencies and with other states and has found innovative ways to bring additional federal health dollars into the state. It also has been recognized for its leadership role in various areas of

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.ıealth policy. Further, the Health Policy Authority has realized successes in the absence of a national health policy agenda.

These efforts demanded a great deal of commitment and sacrifice on your part and on the part of those you led. Once again, thank you for your service to the state of Kansas.

Sincerely,

Senator Jim Barnett, Chairman
Joint Committee on Health Policy Oversight

Representative Melvin Neufeld, former Chairman

Senator Jeff Colyer
Senator David Haley
Senator Laura Kelly
Senator Roger Reitz
Senator Vicki Schmidt
Senator Susan Wagle
Representative Bob Bethell
Representative Bill Feuerborn
Representative Don Hill
Representative Brenda Landwehr
Representative Peggy Mast
Representative Louis Ruiz
Representative Jim Ward

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KANSAS HEALTH POLICY AUTHORITY

Joint Committee on Health Policy Oversight

June 12, 2009

Joe Tilghman
KHPA Board Chair
Kansas Health Policy Authority

Good morning Mr. Chairman, Madam Co-Chair and members of the committee. I am Joe Tilghman, a retired regional administrator for The Centers for Medicare and Medicaid Services, and the current chairman of the Kansas Health Policy Authority Board (KHPA).

My presentation this morning will consist of two sections. The first section will consist of a brief update on KHPA. The second section will discuss the proposed review process for KHPA.

Update

In my early years as an executive at HCFA (now CMS) I naively gave a number of pep talks to staff and contractors using white water rafting as an analogy.

I would say we currently have to negotiate a bad stretch of rapids, but that we'll soon be through them into a nice, relaxing stretch of calm water. After giving that same pep talk for a couple of years it gradually began to dawn on me that there was, in fact, no calm water ahead--Just more rapids. Anyway, here are some of the "rapids" we're currently negotiating at KHPA.

Loss of our Executive Director

As you know Marci Nielsen recently returned to the University of Kansas Medical Center. Her deputy, Dr. Andy Allison, was appointed acting Executive Director. The board has a 2-day retreat next week and one of our top priorities will be to move quickly on hiring a permanent executive director. We will keep you posted on our actions in this area.

Hiring an OIG

I'm happy to report that we have a number of very promising candidates for the vacant OIG position. One of the board's tasks next week will be to set the process in place for interviewing finalists. I'm hopeful that we'll have a selection made this summer and ready for Senate confirmation this fall.

Monitoring Events in Washington

In addition to health care reform we anticipate there will be a great deal of focus on Medicaid and S-Chip this year, as well as a close review of how states are using ARRA stimulus funds. We will monitor these closely not only to avoid any nasty surprise, but also to make sure we're well positioned to take advantages of any new opportunities to help the people of Kansas.

Reacting to the Economic Situation

Dr. Allison, in particular, has been very adept at predicting how current economic issues will be impacting the Medicaid and SCHIP programs. If we can get a good sense of what's going to happen we can do a better job of preparing for it. Needless to say, hard economic times lead not only to a growth in our programs, but also put a

severe strain on the safety net clinics that provide care to the uninsured. Senator Barnett has expressed a clear concern that we keep an eye out for the safety net providers. I understand you'll be discussing this later.

Absorbing Staff and Budget Cuts

One of our biggest tasks next week will be to see how we need to reconfigure KHPA to reflect the new staffing and budget levels. It's certainly doable, but we want to make sure we do it the right way. This is one area in particular where any guidance from you would be greatly appreciated. Any other thoughts along these lines are welcome as we go about trying to reinvent ourselves.

That concludes the update portion of my presentation.

Review Process

To turn now to the proposed review process for KHPA, I want to say on behalf of the board that we welcome a comprehensive, well-structured oversight process. From what I've seen on the draft procedures, I'd say we're off to a great start to do just that. I'm really pretty comfortable proceeding with the draft process as it stands, but do want to make several cautionary statements based on 34 years in a federal agency that was reviewed by just about everyone.

1. It is good to include the Governor's office. It has always made me a little nervous to see what would normally be a part of the Executive branch getting so much oversight from the Legislative branch. I am gratified to see that the draft review plan includes the Governor's office in the process. I hope these provisions are retained.
2. There should be continuity through changes in political leadership in the Legislature and/or Governor's office. While we want to be responsive to political leadership, we also need to be buffered to some extent. Unlike a change in Governor where there's a corresponding change in cabinet membership, KHPA staff and Board membership don't change – and we don't change by design. The same is true for a change in House or Senate leadership. If we painted the wall purple in accordance with the wishes of last year's political leadership, and the new political leadership thinks it should have been painted orange, I certainly don't see that as a performance issue on our part, but rather as a change in political direction. I hope the proposed review process takes this into account.
3. The absence of a benchmark. We got a new puppy last year, and I tell people with great pride that Baxter finished third in his obedience class. What I don't tell there is there were only three dogs in his class. My point is that any evaluation done without familiar benchmarks can be difficult in interpret. Some of the best evaluation feedback we received at CMS was how we compared to other federal agencies. This is something we all need to keep in mind when evaluating a single State agency in a vacuum.
4. We need to build some flexibility into the process. It's hard to plan today how we should run – let alone evaluate – our programs over the next 1-2 years. I doubt that a year ago anyone in this room foresaw a global financial crisis, the bankruptcy of Chrysler and GM, and the existence of a trillion dollar federal stimulus program. When the world around us changes, we have to be nimble enough to change with it. I hope the review process isn't so rigid that it gets in the way of changes we need to make to stay relevant in a changing world.
5. Last point: and this one is a little sensitive – it takes me back to what I had beat into me as a career bureaucrat who had to deal with an ever changing array of political appointees and elected officials. On the one hand, we very much want to hear from you as to what course corrections we need to make to help us all get through some tough times ahead. We want you to tell us what we're doing well and what you want us to continue doing well. We also want to hear about what you think we don't do well, or should do differently, or should stop doing altogether. The Board and KHPA leadership will always pay a great deal of attention to guidance coming from our elected leaders. We place a very high value on that.

Here's the sensitive part. Our primary guidance will always come from the State and Federal law as it currently stands in the books. Whenever there is a conflict between what the law says we should be doing and what some individuals say we should or should not be doing, we will always follow the law. That's how I stayed out of prison for 34 years as a career bureaucrat. My sense is that a lot of folks are uncomfortable with KHPA recommending things like smoking bans and tobacco taxes at the beginning of each legislative session. If you really don't want us doing this, the law needs to be changed. I ask that you please don't set up a review process that evaluates us based

on the preferences of political factions as opposed to what the law requires us to do. That concludes my testimony. I'll stand for questions.

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Update from the Kansas Health Policy Authority: Impact of FY 2010 Budget Decisions

Joint Committee on Health Policy Oversight
June 12, 2009

Dr. Andrew Allison, KHPA Acting Executive Director

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Brief Update on Agency Activities

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KHPA Accomplishments for 2008-9

- Completed 2008 Medicaid Transformation Process to Reform Kansas Medicaid
  - 14 reviews completed; 12 additional reviews underway in 2009
  - Identified $millions in ongoing savings to Medicaid
- Developed Medical Home Model of Delivery
  - Creating incentives for payment reform to promote improved health outcomes and lower health care costs
- Improved Payments for Hospitals that Treat Low-Income Patients
  - Reforms to the Disproportionate Share Hospital (DSH) payment method
  - Increased funding for graduate medical education in underserved areas
- Provided Wellness Programs for State Employees
  - More than 76,000 employees/dependents eligible to participate
- Expanded web-based services for beneficiaries
- Maximized value of Federal stimulus dollars for Kansas
  - Policy input helped inform Congressional debate that improved funding formula for Kansas

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Medicaid Transformation: Savings Estimates for FY 2010

Savings included in KHPA Medicaid Caseload	SGF	All Funds
Expand PDL w/mental health	0	0
Time Limit MediKan to 18 months (reduced resource item)	- $11,700,000	-$11,700,000
Pharmacy changes* (cost reimbursement for physician office administered drugs; improved cost avoidance; updated list of maximum prices; improved enforcement of third-party liability)	4,400,000	-11,000,000
Automatic prior authorization	-300,000	-750,000
Ensure Medicare hospital payments	-2,820,000	-7,050,000
Home health reforms	-120,000	-240,000
Durable medical equipment reforms	-160,000	-400,000
Transportation broker	-200,000	-500,000
Restrictions to hospice payments	-300,000	-750,000
Total Estimated Savings	- $20,000,000	-$32,390,000

*Implemented during FY 2009. Preliminary results suggest higher overall savings.

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Medicaid Transformation: Update on 2008 Recommendations

- Home Health Reforms
  - Policies to be implemented in October to require prior authorization of services, limit acute care visits
- Durable Medical Equipment
  - Require DME suppliers to show actual cost; reimbursement not to exceed 135% of cost
- Transportation Brokerage
  - Issued an RFP for a transportation broker. Currently in the procurement and negotiation process.
- Hospice Services
  - Tighten payment rules by clarifying vague language in the provider manual

Medicaid Transformation: Update on 2008 Recommendations

- Automate and expand pharmacy prior authorization
  - Implementation has begun with the first group of drugs added in March 2009
  - Implementation of (market-based) maximum allowable cost pricing continues with addition policy changes to be effective October 2009.
- Manage Medicaid Mental Health Pharmaceuticals through expanded preferred drug list
  - Legislative proviso prevents implementation of safety and pricing recommendations
- Transportation Brokerage
  - Issued an RFP for a transportation broker. Currently in the last stages of procurement and negotiation.

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Medicaid Transformation: Ongoing 2009 Reviews

- Eligibility
- Federally Qualified Health Centers/Rural Health Clinics *(KDHE)*
- Family planning
- HealthConnect
- HealthWave
- Medicaid operations
- Mental health *(SRS)*
- Monitoring quality
- Prior authorizations for services provided out-of-state
- Physicians
- School-based services
- Therapy services

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Summary of FY 2010 Budget Decisions

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Brief Overview of KHPA's Budget

- **KHPA's FY 2009 budget was about $2.6 Billion**
  - $1.36 billion is non-SGF funding for KHPA medical programs
  - $0.8 billion is federal funds passed through to other Medicaid service agencies (SRS, KDOA, JJA, KDHE)
  - $0.46 billion is SGF funding for services and operations
- **KHPA programs and operations are funded separately**
  - FY 2009 operational funding was $23 million SGF
  - Caseload costs are about 20 times larger than operational costs
  - Caseload savings cannot be credited to cost-saving operations
  - The federal government matches Medicaid operations at 50-90%
  - Operational costs for the state employee plan are funded off-budget
- **KHPA budget reductions concentrated on operations**
  - Medicaid caseload protected due to Federal stimulus dollars
  - KHPA operations reduced 15.5% versus FY 2009

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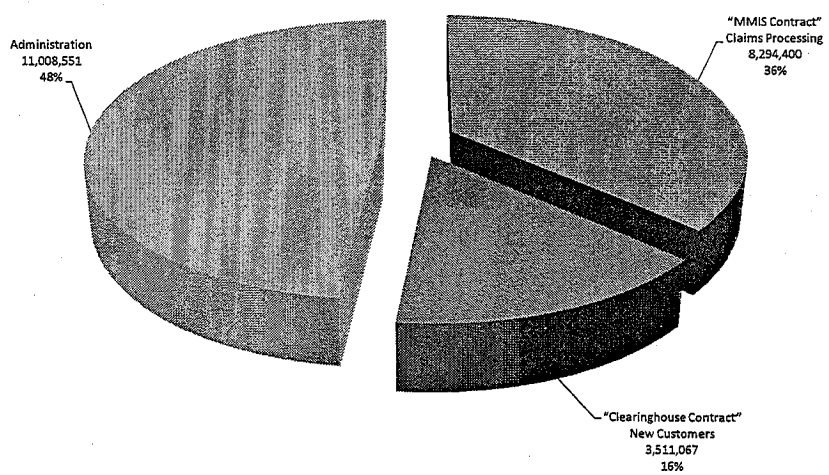
KHPA Operational Budget
Base = FY 2009 Budget: $22,814,018 (SGF)



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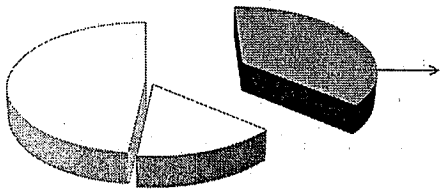
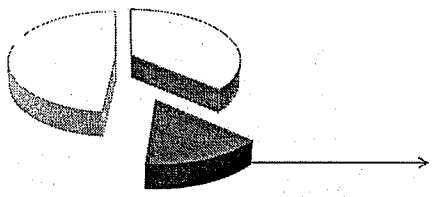
KHPA Functions at a Glance: Claims Processing ($8.3 Million)



- Medicaid Management Information System (MMIS) - federal mandate: data processing system that manages claims and payments; assures compliance with state plan
- Surveillance Utilization Review Subsystem (SURS) - federal mandate: identifies waste, fraud and abuse
- Payment Error Rate Measurement (PERM) – federal mandate; assures program integrity
- Customer and Provider Service Call Centers: answer calls from providers, beneficiaries with billing, eligibility and other questions.
- FY 2009: Processing avg. 1.5 million claims per month
- Disbursing avg. $197 million per month in payments to providers
- Call Centers handling 21,127 incoming calls per month
- Outsourced to independent contractor
- Most costs fixed: volume-based contract

11

KHPA Functions at a Glance: Clearinghouse ($3.5 Million)



- Processes Medicaid and SCHIP applications for coverage: federal mandate to process an application within 45 days
- Similar to a "sales" department in private sector
- Issues new policies
- Screens applicants for eligibility
- Unified application process: One application for family; screens for all eligible services
- Workload fluctuates with economy
- Majority of work outsourced
- FY 2009 – Receiving an average of 10,736 applications and reviews per-month
- ***Backlog of applications already growing as economy worsens***

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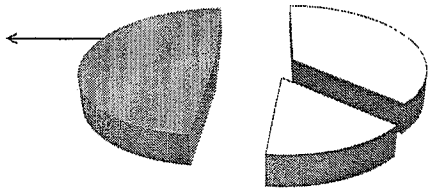
KHPA Functions at a Glance: Administration ($11 Million)

- Finance and Operations: budget; accounting; financial reports; purchasing
- In-house eligibility and claims processing (required by federal law)
- Actuarial Analysis: data evaluation; risk assessment; long-range planning
- Program management: quality improvement; risk management; cost control
- Human Resources
- Information Technology
- Legal Services
- Governmental and Stakeholder Relations
- Communications/Public Relations
- Physical Plant: rent; utilities; equipment; supplies



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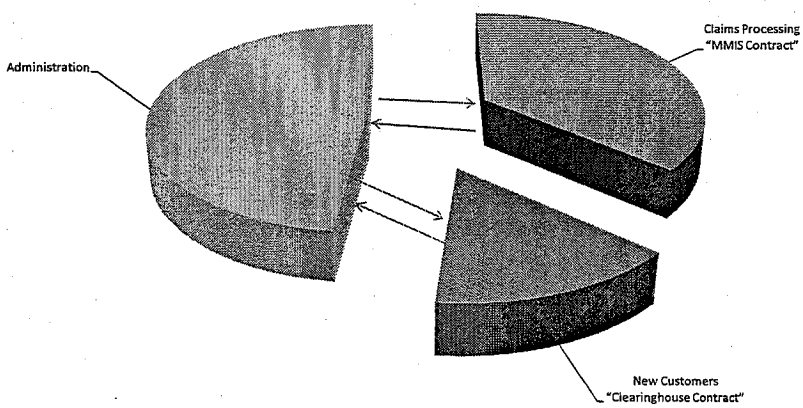
KHPA: Agency Function Interaction



Only portions of Claims Processing and Clearinghouse functions are outsourced. Federal law requires significant involvement/oversight by KHPA staff (for example, final eligibility determination for Medicaid/SCHIP must be made by a state employee, not by a contractor) .

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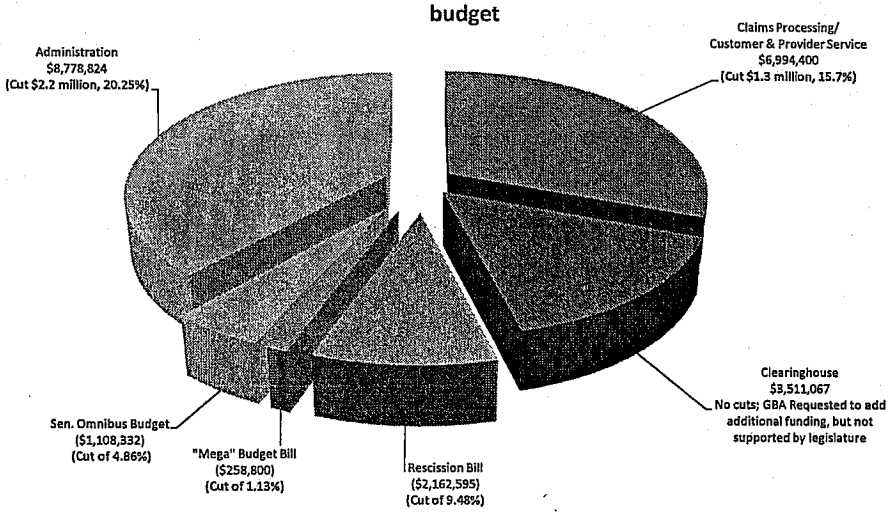
KHPA Operational Budget
Distribution of FY 2010 Budget Cuts as compared to approved base budget



Total Cuts: $3,529,727 (15.47%)

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Potential Impact of Operational Cuts

- **As many as 30,000 to 50,000 People with Delayed Medicaid/SCHIP Applications by December 2009**
  - $25 - $30 Million in uncompensated or foregone medical care, delayed payments
  - $15 - $20 Million in foregone federal funding
  - Needed medical care delayed; negative health outcomes
  - Compliance with 45-day limit for eligibility processing at risk
- **Approximately 40% Cut in Customer and Provider Service**
  - Affects 20,000+ Medicaid providers' ability to ensure access for their patients; receive prompt payment for services
  - Immediate delays in pharmacy care
  - 300,000 beneficiaries lose resource to resolve eligibility, coverage questions
  - Increase customer service demand on SRS, Aging, JJA
- **Staff Layoffs: 13 positions (beginning July 2010)**
  - Another 30+ funded positions held open or eliminated with turnover
  - Cumulative reduction in staffing of 15%
- **KHPA staff will be working to minimize the impact of reductions**
  - Meet regularly with the Medicaid community to identify additional efficiencies and new approaches
  - Continue to scrutinize operational funds to identify new resources
- **Medicaid stimulus funding for Kansas was used to protect Medicaid services and provide state fiscal relief, but stimulus funds were not used to protect Medicaid operations**
  - Federal stimulus dollars for Medicaid prevented cuts to Medicaid caseloads but fewer State General Funds were then provided to keep Medicaid operations whole

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Adjusting to New Targets

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Circumstances differ dramatically from those facing KHPA at its inception in 2006

- **New economy**
  - Immediate reductions in funding for KHPA operations
  - Reductions possible in operations and services in FY 2010
  - Large structural deficit that grows substantially with expiration of Federal stimulus dollars in 2011
- **New state leaders**
  - Transition in KHPA leadership
  - Transition in statehouse since KHPA's founding
- **New federal administration**
  - New President focused on quickly advancing major health care reforms
  - Former Governor Sebelius in position of national leadership
  - Reform options encompass much of KHPA's health policy agenda

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Summary of Agency Response to FY 2010 Budget Shortfall

- **Reduced internal operational costs by $2.2 million SGF**
  - Eliminated contracts not directly related to program operation
  - Cumulative staff reductions of 15%
  - Eliminated policy division
  - Reduced executive positions from 5 to 4, eliminating more than 20% of executive salaries
- **Reduced contract operations by $1.3 million SGF**
- **Will review agency's structure and focus with KHPA Board June 16-17**
  - Re-assign resources to core program operations
  - Maintain efforts to identify savings and efficiencies in program costs
  - Extend focus on data driven efficiency to all KHPA programs
  - Review organizational structure to emphasize efficiency and accountability
  - Revisit policy, communications, and outreach efforts

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Next steps

- KHPA Board retreat June 16-17
- Solicit legislative input on Agency priorities
- Prepare for future budget discussions
  - Acknowledge the size and importance of the state's deficit
  - Engage with policymakers, solicit their input, and help them set a future course

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KAMU unity
THE PRIMARY CARE ASSOCIATION OF KANSAS | advocacy

Testimony on:
Update and Long-Range Planning for Safety Net Clinics

Presented to:
Joint Committee on Health Policy Oversight

By:
Cathy Harding
Executive Director

June 12, 2009

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THE PRIMARY CARE ASSOCIATION OF KANSAS advocacy

Good afternoon Mr. Chairman and members of the Joint Committee on Health Policy Oversight. I am Cathy Harding, Executive Director of the Kansas Association for the Medically Underserved (KAMU). I appreciate the opportunity to provide you an update on Kansas Safety Net Clinics and discuss our long range plans for Safety Net Clinics in Kansas.

Established as a 501(c)3 non-profit organization in 1989, KAMU was designated the state Primary Care Association by the Bureau of Primary Health Care in 1991 and maintains that designation today. As the PCA, KAMU represents 42 members, including 38 safety net clinics. These 38 Safety Net Clinics along with their 25 satellite sites provide Kansans a total of 63 health care access points. Membership includes public and private non-profit primary care clinics, Federally Qualified Health Centers (FQHC's), one Federally Qualified Health Center Look-Alike, local health departments and the Statewide Farmworker Health Program.

KAMU's purpose is to grow and strengthen safety net clinics so that all Kansans will have a primary health care "home". This home is a place where people receive comprehensive primary, dental and behavioral health care, which cover the spectrum of preventative, acute and chronic health care needs. In addition, this primary health care home is defined by sustained relationships. Clients of our clinics receive care from people who know them. Together, they create a partnership for healthy lifestyles.

KAMU's mission is "to support and strengthen its member organizations through advocacy, education and communication." KAMU members share a mission of providing needed health care services for all people regardless of their ability to pay.

In 2008 our 38 Safety Net Clinics provided primary medical, dental and mental health care for nearly 190,000 underserved Kansans. These Kansans are uninsured, underinsured, and some now unemployed, and they need health care regardless of their ability to pay.

KAMU is recognizing our 20th anniversary this year, and so we celebrate the growth in the number of Kansans served by Safety Net Clinics over the years. This growth has been possible in no small part because of the Kansas Legislature's investment of state funds in grants to the clinics and in programs developed to strengthen their capacity. These funds have been appropriated to the Kansas Department of Health and Environment, which has been the financial steward and partner to KAMU in increasing capacity at the clinics.

The state's investment in Safety Net Clinics is a good one. National data on Federally Qualified Health Centers (FQHC's) – one type of Safety Net Clinic in Kansas – demonstrates cost effectiveness:

- Overall medical expenses for health center patients are 41% lower ($1,810 per person annually) than for patients seen elsewhere.
- In the case of Medicaid patients alone – the total cost per patient nationally is $1,000 less per year.
- There is evidence at the National level to show a six to one return on every dollar allocated to the FQHC's.

7-2

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Investing state dollars in the safety net clinics has a two-fold return: First, it improves health care access for Kansans who would not receive healthcare services otherwise; and, second, it leverages additional funds – federal and local – so that state funds are stretched to increase their impact. The leveraged funds just described are proof that investment in the Safety Net Clinics returns positive results in services, and also has a positive impact on the state budget by leveraging state funds.

At the national level, Congress recognizes the importance of this investment in Community Health Centers. Although state funds for primary care were reduced this year by $288,283, federal funding has grown through the American Recovery and Reinvestment Act (ARRA). Although these changes will positively impact Kansas' federally funded Community Health Centers with operations and capital needs, nearly 2/3 of the safety net clinics are not federally funded so have no access to these funds. Furthermore, operational ARRA dollars to the Community Health Centers are clearly earmarked for growth to serve more people, with that growth expected to continue after the two-year funding ends. The cut in state appropriations will decrease capital funds to the clinics, and as a result the cap for these grant funds is reduced from the SFY 2009 level of $100,000 to just $50,000 in SFY 2010.

Recognizing that the safety net clinics are filling a key role in the state's health care system, the Senate Public Health & Welfare Committee directed KAMU during the past Legislative Session to develop a 5 – 10 year safety net growth plan. Representatives from KDHE, KHI and KHPA assisted us in developing a plan to actually develop such a plan, which was presented to the Committee. As part of this planning process, KAMU has scheduled a two-day "Kansas Healthcare Access Workgroup" meeting on June 30 and July 1, with top level leadership from the Kansas Hospital Association, Kansas Health Institute, Kansas Department of Health and Environment, Kansas Medical Society, Kansas Health Policy Authority, Kansas Association of Community Mental Health Centers, Kansas Department of Commerce (Rural Policy), Kansas Dental Association, Kansas Association of Local Health Departments and Kansas Public Health Association. This two-day discussion will provide the background for the safety net growth plan, and consider the safety net in a larger 'systems of care' perspective that includes many partners throughout the state.

Our directive from Public Health & Welfare is to provide this long-term growth plan to the Joint Committee on Health Policy Oversight before the start of the next legislative session. KAMU welcomes this opportunity to lead the discussion with our partners to plan a system of care that will best meet the healthcare needs of all Kansans.

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The Kansas Safety Net

Update and Vision

Overview

- The Safety Net
  - 38 Clinics
    - 14 FQHCs
    - 1 FQHC Look-Alike
    - 23 Primary Care Clinics
  - 65 Access Points
  - Medical, Dental and Behavioral Health
  - Health care "homes"

KAMU

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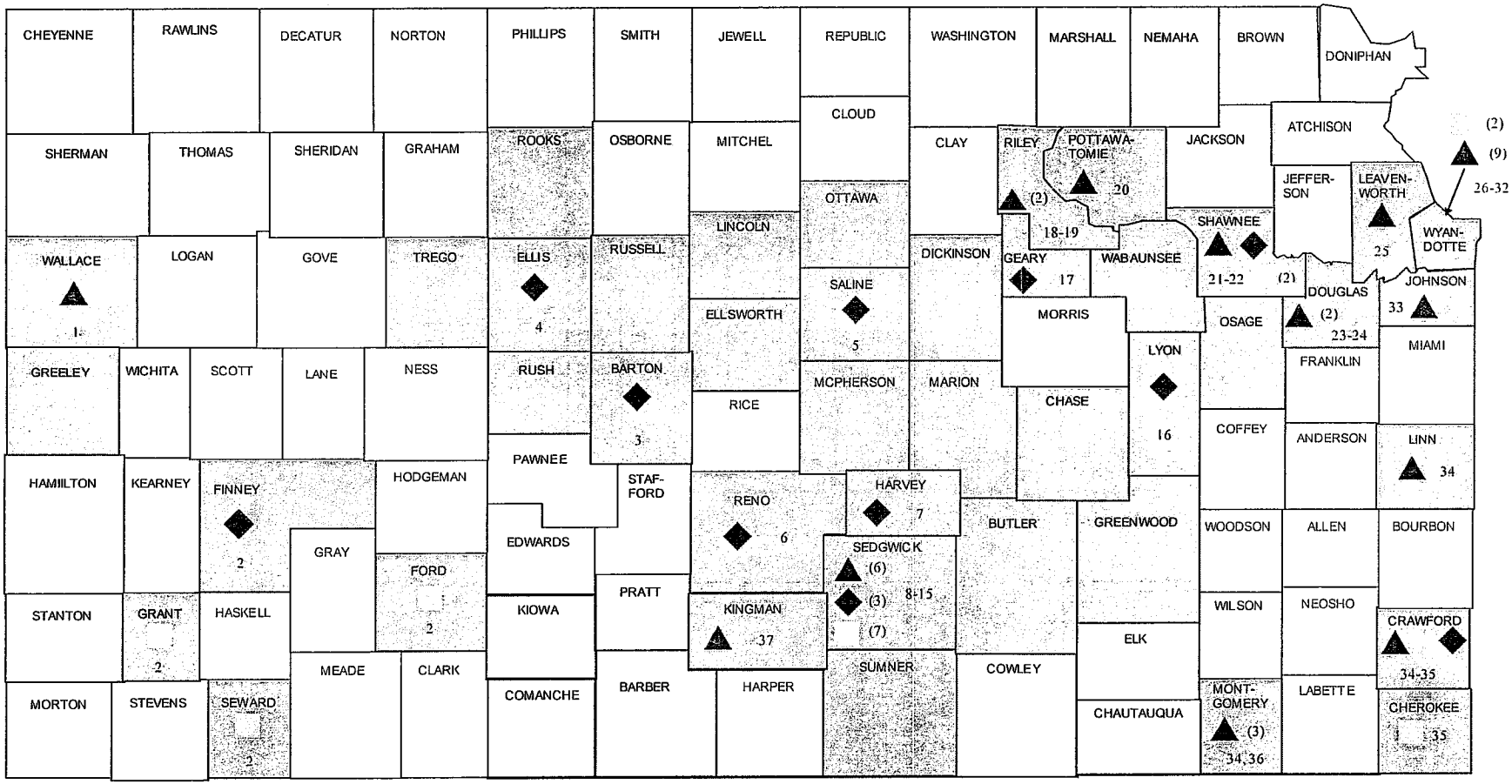
Kansas Primary Care Safety Net Clinics and Satellite Locations



Safety Net Provider Sites
FQHC and FQHC Look-Alike Main Sites
FQHC Satellite Sites
Service area

Statewide: The Kansas Statewide Farmworker Health Program has 128 access points.

1. Wallace/Greeley County Health Services
2. United Methodist Mexican American Ministries, Inc. (UMMAM)
3. Heart of Kansas Family Healthcare, Inc.
4. First Care Clinic of Hays
5. Salina Family Health Care Center
6. PrairieStar Health Center
7. Health Ministries Clinic
8. Center for Health and Wellness
9. Good Samaritan Health Ministries
10. GraceMed Health Clinic, Inc.
11. Guadalupe Clinic, Inc.
12. Healthy Options for Kansas Communities (HOP)
13. Hunter Health Clinic
14. Mother Mary Anne Clinic
15. St. Mark, E.C. Tyree Health Clinic
16. Flint Hills Community Health Center
17. Konza Prairie Community Health Center
18. Riley County Community Health Clinic
19. Flint Hills Community Clinic
20. Community Health Ministry Clinic
21. Marian Clinic
22. Shawnee County Health Agency
23. Health Care Access
24. Heartland Medical Clinic
25. Saint Vincent Clinic
26. Children's Mercy West, The Cordell Meeks, Jr. Clinic
27. Duchesne Clinic
28. KU Health Partners / Silver City Health Center
29. Mercy and Truth Medical Missions
30. Southwest Boulevard Family Health Care
31. Swope Health, Wyandotte and Quindaro
32. Turner House Children's Clinic
33. Health Partnership of Johnson County
34. Mercy Health Systems: Pleasanton, Arma and Cherryvale Rural Health Clinic (RHC)
35. Community Health Center of Southeast Kansas
36. Montgomery County Community Clinic (MC3)
37. St. Gianna Health Clinic

6/9/09

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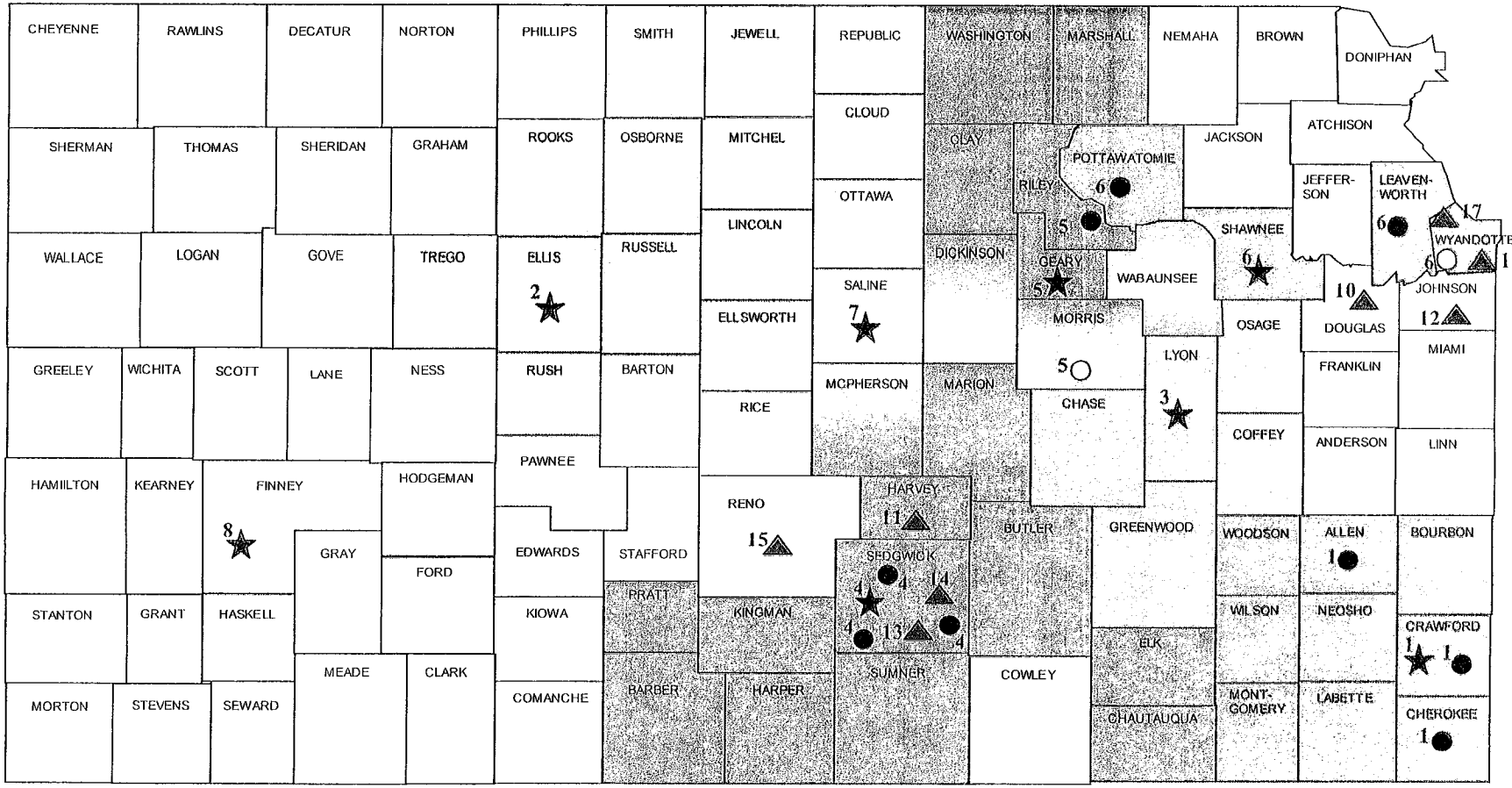
Safety Net Dental Clinics, Dental Hubs, and Spokes



Clinics receiving Dental Hub funding from the State and/or Private Foundations

1. Community Health Center of South East Kansas & Spokes
2. First Care Clinic of Hays
3. Flint Hills Community Health Center
4. GraceMed Dental Clinic, Inc. & Spokes
5. Konza Prairie Community Health Center & Spokes
6. Marian Clinic & Spokes
7. Salina Family Health Care Center
8. United Methodist Mexican-American Ministries, Inc.
9. Community Health Ministries

Other Safety Net Dental Clinics

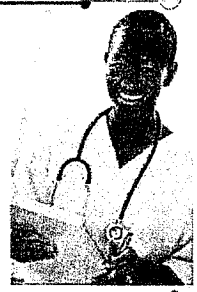
10. Douglas County Dental
11. Health Ministries Clinic
12. Health Partnership of Johnson County
13. Healthy Options for Kansas Communities
14. Hunter Health Clinic
15. PrairieStar Health Center
16. Southwest Boulevard Family Health Care
17. Swope Health, Wyandotte and Quindaro

Service area (Shaded)
★ Existing Hub
☆ Planned Hub
● Existing Spoke
○ Planned Spoke
▲ Safety Net Dental Clinic

6/9/09

Update

- Growth
  - In 2008
    - 189,422 patients served
    - 566,689 patient visits
    - 104,766 uninsured patients (57.9% of all pts)
    - 98,023 below 100% FPL (65.9% of all pts)
    - 139,141 below 200% FPL (93.6% of all pts)



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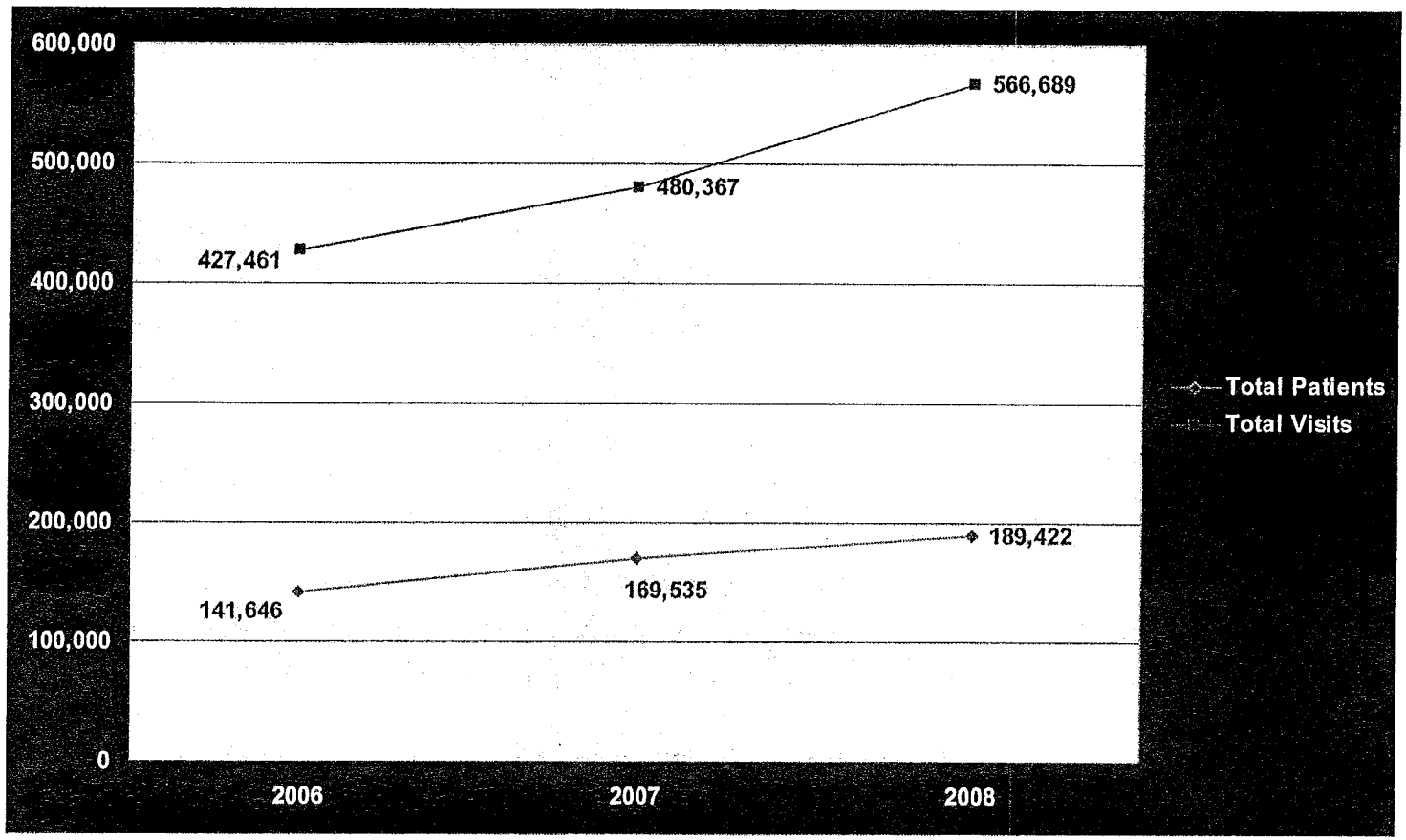
Patients & Visits



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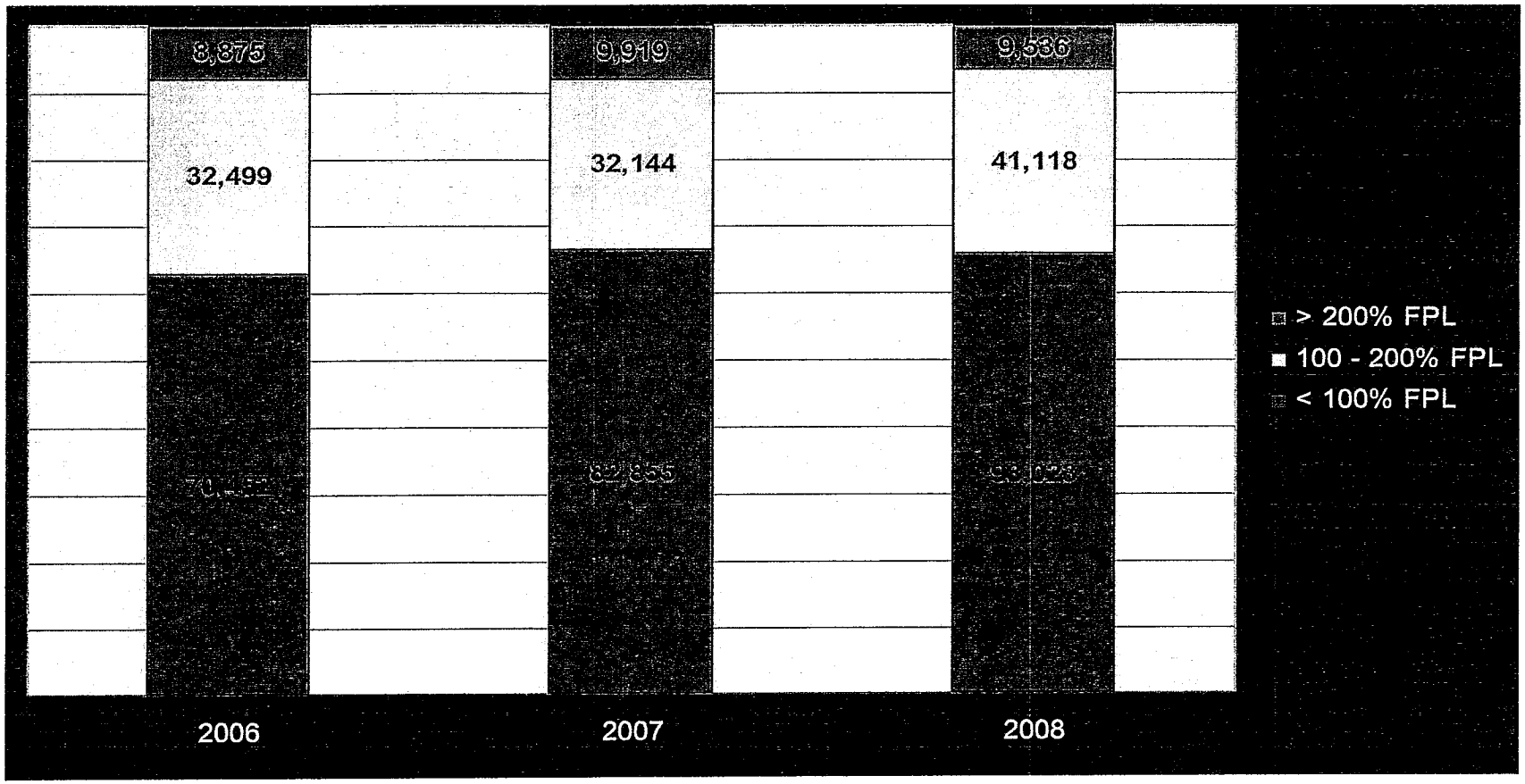
Patient Poverty Status



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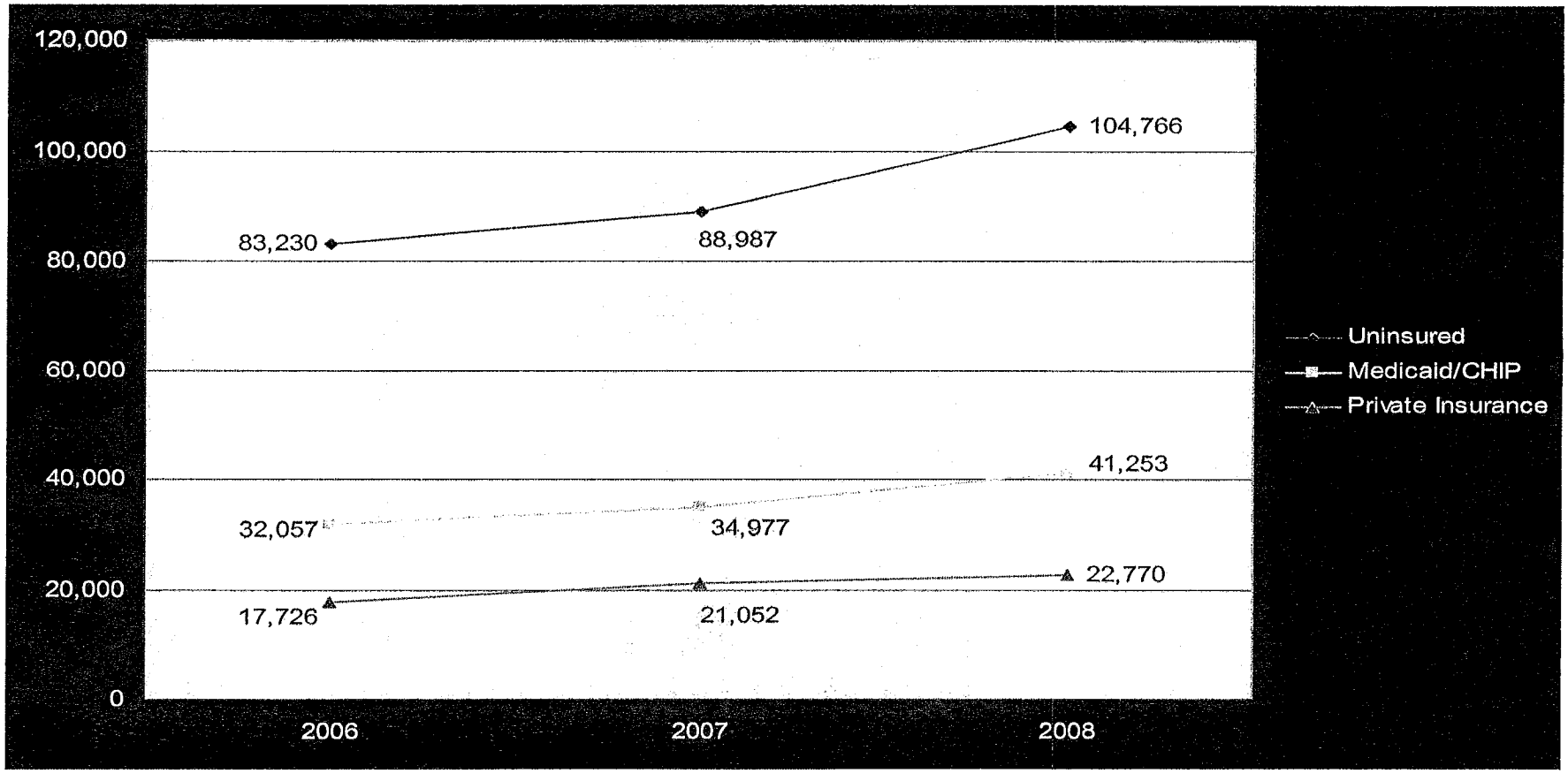
7-16

Patient Payer Source



KAMU

Funding Status

- State Appropriation
  - $288,283 decrease
- Federal Funds
  - ARRA
  - New FQHCs

KAMU

State Appropriations

- Grants to Clinics for Direct Operations
- KAMU/KDHE Contract
  - Workforce Development
  - Technical Assistance
  - Capital Improvement Grant Program
    - Decrease from $700,000 to about $411,717*

KAMU

Impact

- Impacts non-federal clinics most
- Size of capital grant awards reduced

KAMU

9-11

[illegible]

- ARRA
  - Increased Demand for Services Grants
    - $3.2 million over two years
  - Capital Grants
    - $7.1 million
    - Competitive applications for more
- New Community Health Centers

KAMU

Impact

- CHCs
  - Serve more people
  - Expand physical capacity or…
  - Improve IT
- Non-federal clinics
  - No benefit

KAMU

Future

- Clinics filling a critical need
  - Health Reform
  - Budget cuts
- Legislative Directive
  - Public Health & Welfare

KAMU

7-12

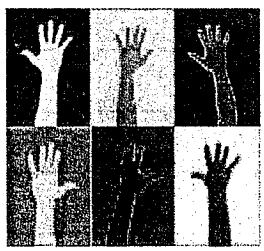
Growth Plan

- "Plan for a Plan"
  - KAMU, KHI, KDHE & KHPA
  - Presented to Public Health & Welfare
- Kansas Access Workgroup
  - June 30 – July 1
  - Health Care System
  - "Larger" safety net

KAMU

Vision

- Share resources
- Integrate services
- Improve "systems" of care
- Consider alternative models
- Fill holes in the safety net



KAMU

7-13

DEVELOPMENT OF KANSAS ACCESS PLAN

Year 1 (to be completed by next Legislative Session) – No fiscal note

1. Conduct a comprehensive environmental scan to include the following components:
    - Statewide assessment of current and projected need
    - Evaluation of existing infrastructure to include:
        - Determine what is working well
        - Evaluate physical and human resource capacity
        - Evaluate current financing/reimbursement
    - Define limitations
        - Services
        - Geographic
    - Evaluate best methods/practices in Kansas and other states
    - Establish a work group (to be appointed by Public Health and Welfare) to develop a 5 – 10 year plan.

2. Determine possible strategies (Work Group)

3. Establish an implementation plan (Work Group)

4. Develop an evaluation plan (Work Group)

Year 2 (2010 Legislative Session) – No fiscal note

1. Report to Public Health and Welfare specific Access Plan recommendations.

2. Introduce legislative and regulatory change recommendations (state and federal).

Years 3 – 5

Implement plan as approved by Kansas Legislature
Evaluate and re-assess (every year)

Years 5 – 10

Determine sustainability issues
Evaluate and re-assess (every year)

KANSAS PUBLIC HEALTH ASSOCIATION, INC.

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June 12, 2009
Joint Committee on Health Policy Oversight
To the Honorable Committee Members:
Sen. Jim Barnett, Chair
Rep. Brenda Landwehr, Vice-Chair
Testimony on: Long-Range Vision for Public Health in Kansas

Thank you, Mr. Chairman and Committee for the opportunity to testify about the "Long Range Visioning for Public Health in Kansas". I am Elaine Schwartz, Executive Director of the Kansas Public Health Association (KPHA) and have been in this position for almost five years.

Sen. Barnett, when you met with the two statewide "public health" organizations in Kansas, the Kansas Association of Local Health Departments (KALHD), and KPHA during the Wrap-up Session to discuss the current status of Public Health in Kansas, we were excited to hear of your desire in looking to the future for where Public Health should be going in Kansas. As you know, following that were several other meetings to discuss the "next steps" with KDHE Secretary Bremby and the state's Health Director, Dr. Jason Eberhart-Phillips. As a result we are all three here today to report on the outcomes of those meetings as to how we plan to begin the Visioning process also to determine "where we have been, where we are now, and where we want to be" in public health. We have been in touch with the Kansas Health Foundation and hope to have a proposal to them for funding shortly. If they support the proposal, we hope to work together in this Long Range Visioning process.

My role, today, is to tell you "where we have been" or the "past efforts of public health". But, first the most important part of that is telling you what Public Health is, in order for you to have a better understanding of the past, present, and future.

As a former Legislator who served for 8 years on the House Public Health and Welfare Committee, I thought I understood what Public Health was and was not. But, when I took the job as the Executive Director for the state's public health association, I learned a lot more about public health than what I learned from serving in the Legislature. I hope to share with you now some of that learning.

On Health Day, this year, we gave all Legislators a copy of our Orientation Manual. The manual was funded through a project grant from the Kansas Health Foundation. Since the manual was developed by many in the public health workforce across the

state it does a superb job of describing what public health is and the history of public health. Its intent was to create a common language for public health for everyone.

So, what is Public Health? Public Health is Prevention. Public Health is the practice of preventing disease and promoting good health within groups of people, from small communities to entire countries. Public Health is policy development and population health surveillance monitoring. Thus, the three P's of Public Health are "Prevention, Promotion, and Protection". **Why is it Important?** Public health saves money and improves quality of life. A healthy public gets sick less frequently and spends less money on health care. This means better economic productivity and an improved quality of life for everyone. Improving public health helps children thrive. Healthy children become healthy adults. Healthy kids attend school more often and perform better overall. Public health professionals strive to ensure that all kids grow up in a healthy environment with adequate resources, including proper health care. Public health prevention educates people about the effects of lifestyle choices on their health. It also reduces the impact of disasters by preparing people for the effects of catastrophes such as hurricanes, tornadoes, and terrorist attacks.

Who Does It? Public Health as a Profession includes professionals from many fields with the common purpose of protecting a population's health. Professions include:

- Health Educators
- Educators and Teachers (of all levels)
- Scientists and Researchers
- Physicians
- Nurses
- Occupational Health and Safety Professionals
- Social Workers
- Epidemiologists
- Nutritionists and Dietitians
- Community Planners
- Lawyers
- Administrators
- Child Care Surveyors
- Veterinarians
- Geologists
- Environmental Health Specialists
- Restaurant Inspectors
- Engineers
- Biologists
- Researchers
- Emergency Responders
- Policymakers (local, state and federal)

It is important to differentiate the **"public health system"** from **"governmental public health."** The public health system includes the diverse array of partners who together perform the essential public health services, while governmental public health (the official local, state, federal public health agencies) are often the "conveners" of the system; accountable for assuring essential services in the

jurisdictions they serve by performing specific functions. These functions will be explained further in the discussion of accreditation standards later in my testimony.

Public health is involved in many activities. The following are some examples:
- Promoting vaccination programs for infants, children and adults
- Regulating prescription drugs for safety and effectiveness
- Setting safety standards and practices to protect worker health and safety
- Ensuring access to clean water and air
- Educating the public to reduce child obesity
- Measuring the effects of air quality on emergency recovery workers
- Ensuring children have access to nutritious food through school nutrition

"The mission of public health is to fulfill society's interest in assuring conditions in which people can be healthy." Institutes of Medicine, the Future of Public Health

Public health carries out this mission through organized, interdisciplinary efforts through national, state, and local agencies through academia, government, and health advocate groups to address the physical, mental, and environmental health concerns of communities and populations at risk for disease and injury. Its mission is achieved through the application of health promotion and disease prevention technologies and interventions designed to improve and enhance quality of life. Health promotion and disease prevention technologies encompass an array of functions and expertise, including the three core public health functions (assessment, policy development, and assurance) and 10 essential services.

Public Health is defined in the following ways:

- The science and practice of protecting and improving the health of a community, as by preventive medicine, health education, control of communicable diseases, application of sanitary measures, and monitoring of environmental hazards. (www.MedicineNet.com)

- The science and the art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, and the organization of medical and nursing service for the early diagnosis and preventive treatment of disease. *(Charles-Edward A. Winslow, 1920)*

- Public health is what we, as a society, do collectively to assure the conditions for people to be healthy. *(The Institute of Medicine, 1988)*

The determinants of health include those factors and the context of people's lives that determine whether or not people are healthy. Factors include: **Income and social status:** Higher income and social status are linked to better health; the larger the gap between the richest and poorest people, the greater the differences in health, (as evidenced by the recent county ranking of health status by KHI.

Education: Low education levels are linked with poor health, more stress, and lower self-confidence. **Physical environment:** Safe water and clean air; healthy workplaces; and safe houses, communities, and roads all contribute to good health. **Employment and working conditions:** Employed persons are healthier, particularly those who have more control over their working conditions. **Social support networks:** Greater support from families, friends, and communities is linked to better health. **Culture:** Customs, traditions, and family and community beliefs affect health. **Genetics:** Genetics play a part in determining lifespan, healthiness, and the likelihood of developing certain illnesses. **Personal behaviors and coping skills:** Eating and exercise habits, smoking, drinking, and how we deal with stress affect health. **Health services:** Access and use of services that prevent and treat disease influences health. **Gender:** Men and women suffer from different types of diseases at different ages.

Public health has many sub fields. It is typically divided into the categories of **epidemiology; biostatistics** and **health services**; and **environmental, social, behavioral, and occupational health.**

In 1885, the first Kansas Board of Health and local boards of health were established by the Kansas State Legislature to "protect the sanitary interests of Kansans." The first division of the State Health Department was Food, Drug & Sanitation, formed in **1904. Dr. Samuel J. Crumbine** was appointed that same year as the first Executive Secretary and served for about 20 years. Dr. Crumbine's campaigns included promoting pure food and drugs; eliminating houseflies and rats; promoting water and sewage sanitary control; and preventing tuberculosis. He succeeded in abolishing the common drinking cup, the common "roller" towel, and spitting on the sidewalk. He led the development of programs which still remain today in our state and the nation. In 1900's the predominant cause of death was infectious disease (tuberculosis, diarrhea and enteritis, diptheria, pneumonia, flu). By 1997, the leading causes of mortality were heart disease, cancer and stroke, preventable, behaviorally-based diseases.

Looking Back: Ten Great Public Health Achievements During the 20th century, the health and life expectancy of persons residing in the United States improved dramatically. Since 1900, the average lifespan of persons in the United States has lengthened by greater than 30 years; **25 years of this gain are attributable to advances in public health**.

Vaccination Motor-vehicle safety Safer workplaces Control of infectious diseases Decline in deaths from coronary heart disease and stroke Safer and healthier foods Healthier mothers and babies Family planning Fluoridation of drinking water
Recognition of tobacco use as a health hazard

Work began on identifying the future role of public health in a reformed health care system. The first step was to create common terms and descriptions of the functions. Though the three core functions of public health developed by the Institute of Medicine were widely accepted among the public health policy and academic community, the core functions did not explain to legislators or the general public

what public health does. An attempt to further define the functions of public health was included in President Clinton's **Health Security Act of 1993**. To coordinate a single list for the public health community to use, **the Core Public Health Functions Project** was developed. The Essential Services Work Group was formed to further refine the language. The Public Health in America statement was developed, reviewed, and adopted and in 1995, the name of this group was changed to the Public Health Functions Working Group and Steering Committee.

Subsequently, the **"Ten Essential Services"** of public health were developed by a national committee of public health professionals and are recognized today as the foundation for defining public health. The essential services provide an excellent framework for an operational definition of local health departments:

1. **Monitor health status to identify community health problems**
2. **Diagnose and investigate health problems in the community**
3. **Inform, educate, and empower people about health issues**
4. **Mobilize community partnerships to identify and solve health problems**
5. **Develop policies/plans that support individual and community health efforts**
6. **Enforce laws that protect health and ensure safety**
7. **Link people to needed personal health services**
8. **Assure a competent public health and personal health care workforce**
9. **Evaluate personal and population based health services**
10. **Research for new solutions to health problems**

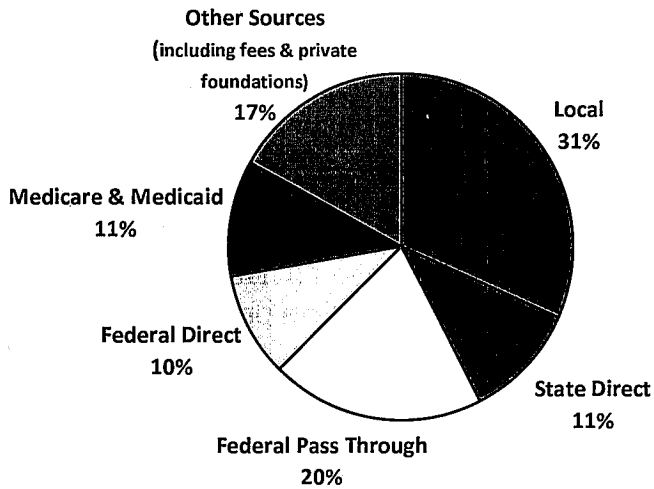
The national operational definition provides the basis for accountability measures and clarifies what the public should expect from local health departments in terms of public health preparedness and responsiveness for public health threats. The operational definition provides a much-needed framework to assist in securing funds and establishing methods and measures of accountability. With funding from the U.S. Centers for Disease Control and Prevention (CDC) and the Robert Wood Johnson Foundation, the **Exploring Accreditation** project began in August 2005 with a goal to determine the feasibility and desirability of implementing a voluntary national accreditation program. The project was established by a planning committee of executive directors from the American Public Health Association (APHA), Association of State and Territorial Health Officials (ASTHO), National Association of County and City Health Officials (NACCHO), and National Association of Local Boards of Health (NALBOH).

In order to further explain public health you need to know how public health programs have been funded in the past. Money can come from state and federal sources, through specific state taxes, from fines and fees (both local and state), and from private industry or private foundation support. **Federal funds come from sources within various agencies of the U.S. Department of Health and Human Services**. The Health Resources Services Administration (HRSA), the Bureau of Maternal and Child Health and the CDC provide funds to states directly through grants and contracts. Federal funds are likely to be categorical, meaning funds are specifically targeted at a disease or an activity such as breast cancer screening or immunization campaigns and are restricted to their stated purpose.

Of the federal sources, the Bureau of Maternal and Child Health tends to award funds to states as **block grants, allowing states more discretion over how the money is allocated**. State health departments may have some flexibility in deciding what projects receive state funds and how much, depending on the level of federal or other support. Projects such as sexually transmitted disease control are almost totally funded by either federal money or by a combination of federal and other funding sources. Local fees (tax levies and fines) support many local public health programs. An example of a fee would be a local tax on sales of durable goods or property taxes. An example of a fine would be a citation for a restaurant that was found to be unsanitary by the local health officer. Together with state funding, these two sources are the largest financial contributors to public health programs. **Our national organization-APHA has encouraged state associations to work with their State Legislatures to secure funding for public health from the new stimulus funds.**

According to the most recently published profile of health departments across the country and specifically in Kansas, we can see that **funding for governmental public health** is complex, see figure below.

http://www.naccho.org/topics/infrastructure/profile/upload/NACCHO_report_final_000.pdf



Private corporations and foundations also can help support local and state health programs. Insurers (e.g., Blue Cross and Blue Shield) and pharmaceutical companies (e.g., Pfizer) have worked with agencies on various public health activities. Both state and local foundations also have provided financial support to public health projects such as the establishment of immunization registry programs and promoting antismoking advertising aimed at youth. In Kansas we are very lucky to have the "Health Foundations" we have such as KHF, UMHMF, Sunflower, REACH, etc. that fund much of public health in our state. In short, Public Health Funding is complex and comes from multiple streams.

Before I turn this over to Edie to bring you to the "present" or current happenings in public health in Kansas, I wanted to also share what KPHA (which has members

from all sectors of public health in Kansas--governmental, academia, school health, and non-profits) hopes the outcome of this proposal will be. We realize that looking at public health infrastructure is not happening in a vacuum. Much good work is already in place and there have been previous efforts to review public health. We intend to build on the recommendations of the **Governor's Public Health Improvement Commission for the State of Kansas in Fulfillment of the *Turning Point Grant,*** funded by the Robert Wood Johnson Foundation, the W.K. Kellogg Foundation and the Kansas Health Foundation in 1999. Indeed, several important outcomes were achieved, including workforce development initiatives such as the Core Public Health Program (CPH), KPHLI, and the MPH programs. There were definitely additional recommendations that were not implemented due to a variety of factors, including funding and political will, among others.

Secondly, we want the **Planning Goals** for this effort to be: creating **consistent basic public health infrastructure** and services across the state; creating a common set of expectations for public health (aligned with draft/final PHAB standards); and **defining responsibilities and functions for both local and state public health**. And, we want finally to make sure there is an integration of public health services across the state, and an **increased accountability** for public health in Kansas. We would also like to see **movement begin toward establishing a School of Public Health** in Kansas.

We already have a great list of **facilitators** for a statewide year long study. We hope a **Steering Committee** will be established to recruit leaders across the system to contribute and serve to review **Public Health Infrastructure** and Standards (using PHAB Draft/Final Standards as reference); review **Data Systems** and Information Support, and review **Public Health Financing**. We also want to make sure we are not duplicating any current planning processes underway. The movement toward accreditation will create a stronger focus on quality improvement and accountability in governmental public health, along with consistent expectations of public health across jurisdictions. One of the important outcomes of this process would be that all people of Kansas receive consistent health promotion and protection benefits from their public health agencies.

I hope this little "history lesson" has not bored you with the past but has helped you to better understand Public Health in general. As a Legislator you are asked to learn so much in our state, from education to taxes, to insurance, to agriculture, to banking, and all the other issues needed to be ruled by law. Public Health is just a small fraction of what you deal with under the dome, and we sincerely appreciate your support and consideration of what is happening on the public health front.

In conclusion of my portion of the testimony before the Committee, I would like to once again thank you all for this opportunity. I will be happy to stand for questions upon the conclusion of both Edie Snethen with KALHD talking about the "Present" where we are now and Dr. Jason Eberhart-Phillips who will be talking about the "Future" of where we want to be in Public Health in Kansas. We invite you to join us in our efforts! And, once again we thank you for yours.

This Manual was handed out to all Legislators on Health Day during the 2009 Legislation. It goes into more detail of public health in Kansas. If you need an additional copy, please let us know. If you finished using your copy, your county health department would be happy to receive it for their orientation of new hires.

Healthy People Build Strong Communities

An Orientation to Public Health in Kansas

2009

Why now?

Kansas Public Health Long-Range Vision

1. Health Reform and the Crucial Role of Prevention

The United States far exceeds every nation in the world in health care spending, yet has a health system that is outperformed by 36 countries. The time is right to transform our approach to health and health care. Only by addressing the preventable conditions that lead to poor health and high health care costs can we achieve lasting solutions to the problems that ail our health system.

There are three types of prevention:

Primary prevention involves taking action before a problem arises in order to avoid it entirely, rather than treating or alleviating its consequences.

Secondary prevention is a set of measures used for early detection and prompt intervention to control a problem or disease and minimize the consequences,

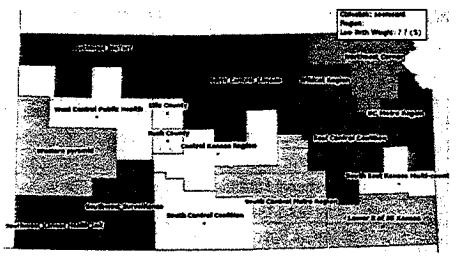
Tertiary prevention focuses on the reduction of further complications of an existing disease or problem, through treatment and rehabilitation.

2. Important Health Issues in Kansas

Population health in Kansas has recently been on the front pages with the release of the County Health Profile Rankings published by the Kansas Health Institute. Not many months back, the United Health Foundation published a similar effort when it released America's Health Rankings which provided state health rankings. Kansas received an overall ranking of 22 and a copy of the Kansas Profile is attached. I call your attention first to the fact that our lowest Health Outcomes Ranking is in the area of infant mortality. The report also shows under Clinical Care, Adequacy of Prenatal Care, only 69.8% of pregnant women receive adequate prenatal care. The Healthy People 2010 goal for this indicator is 90%. To demonstrate the role of Kansas Public Health in prevention, I will very briefly describe some work that is being done today by local health departments to impact this important health outcome. This is but one example, but as noted in the America's Health Ranking Report for Kansas, it is the health outcome with the lowest ranking and demonstrates one interface between the local public health department and safety net clinics.

3. The Role of Public Health in Prevention

Kansas Health Rankings 2009
Kansas Health Institute
Low Birth Weight
Kansas 7.2%
Gold Areas- Rate > 7.6%



Examples of Public Health Activity to Improve Birth Outcomes

Sedgwick County Health Department
http://www.sedgwickcounty.org/healthdept/healthybabies.asp

- Northeast Wichita Healthy Start Initiative targets 3 inner-city zip code areas where the 2006 African-American Infant Mortality Rate was 24.17%.
- Healthy Babies- Registered Nurses and Community Liaisons provide group education, family support and home visits (as needed) during the pregnancy and after baby is born.
- Maternal & Infant Services

Lower SE 8 Region (8 Local Health Departments)
Quality Improvement Project
http://www.kalhd.org/lower8/

- Reduce barriers for access to prenatal care
- Share best practices among region
- Target intervention- improving process to assist clients in completing Medicaid/Healthwave application

Northeast Corner Region (2 Local Health Departments)
Quality Improvement Project
http://www.kalhd.org/necorner/

- Client surveys to identify barriers
- Coordination between lhds & safety net clinic

KAL

Joint Committee on Health Policy Oversig
6/12/09
Attachment 9

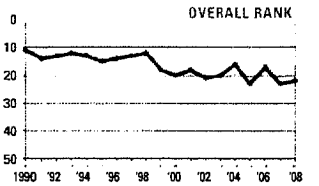
Overall Rank: 22
Change: ▲1

Strengths:
- Few poor mental and physical health days
- High immunization coverage
- Low prevalence of smoking

Challenges:
- Low per capita public health funding
- Limited access to primary care
- Moderate rate of preventable hospitalizations

Significant Changes:
- In the past year, the prevalence of smoking decreased by 11%
- In the past year, the percentage of children in poverty declined by 12%
- Since 1990, the incidence of infectious disease decreased by 67%
- Since 1990, the rate of uninsured population increased by 39%

Ranking: Kansas is 22nd this year; it was 23rd in 2007.



Strengths: Strengths include few poor mental and physical health days per month at 2.6 days and 3.1 days in the previous 30 days, respectively, a low incidence of infectious disease at 7.7 cases per 100,000 population, a low prevalence of smoking at 17.9 percent of the population and high immunization coverage with 81.7 percent of children ages 19 to 35 months receiving complete immunizations.

Challenges: Challenges include low public health funding at $39 per person, limited access to primary care with 100.5 primary care physicians per 100,000 population, a high occupational fatalities rate at 7.3 deaths per 100,000 workers and a moderate rate of preventable hospitalizations with 80.8 discharges per 1,000 Medicare enrollees. Kansas ranks lower for health determinants than for health outcomes, indicating that overall healthiness may decline over time.

Significant Changes:
- ▼ In the past year, the prevalence of smoking decreased from 20.0 percent to 17.9 percent of the population.
- ▼ In the past year, the percentage of children in poverty decreased from 19.7 percent to 17.4 percent of persons under age 18.
- ▼ Since 1990, the incidence of infectious disease declined from 23.3 to 7.7 cases per 100,000 population.
- ▲ Since 1990, the rate of uninsured population increased from 9.0 percent to 12.5 percent.

Health Disparities: In Kansas, low birth weight babies are more common among non-Hispanic blacks at 13.4 percent than non-Hispanic whites at 7.0 percent. Access to health care varies significantly by race and ethnicity in the state; 44.0 percent of Hispanics lack health insurance, compared to 12.4 percent of non-Hispanic whites.

State Health Department Web Site: www.kdheks.gov

		2008		2007		2003		1990	
		VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
DETERMINANTS	**PERSONAL BEHAVIORS**								
	Prevalence of Smoking (Percent of population)	17.9⇓	13	20.0	24	22.1	17	30.2	27
	Prevalence of Binge Drinking (Percent of population)	15.0⇑	20	13.9	17	15.3*	24	—	—
	Prevalence of Obesity (Percent of population)	27.7⇑	31	25.9	30	22.8	28	13.1	40
	COMMUNITY & ENVIRONMENT								
	High School Graduation (Percent of incoming ninth graders)	79.2	21	77.9	22	74.5*	17*	84.1*	8
	Violent Crime (Offenses per 100,000 population)	453	31	425	27	405	27	361	21
	Occupational Fatalities (Deaths per 100,000 workers)	7.3	38	6.1	25	6.5	38	11.5*	32
	Infectious Disease (Cases per 100,000 population)	7.7	11	7.9	11	12.2	17	23.3	16
	Children in Poverty (Percent of persons under age 18)	17.4⇓	30	19.7	38	14.4	26	14.3	11
	Air Pollution (Micrograms of fine particles per cubic meter)	10.9	20	10.7	19	12.1	23.0	—	—
	PUBLIC & HEALTH POLICIES								
	Lack of Health Insurance (Percent without health insurance)	12.5	19	11.3	14	10.4	17	9.0	12
	Public Health Funding (Dollars per person)	$39	46	$37	46	—	—	—	—
	Immunization Coverage (Percent of children ages 19 to 35 months)	81.7	13	79.2	35	66.8	45	—	—
	CLINICAL CARE								
	Adequacy of Prenatal Care (Percent of pregnant women)	69.8*[1]	—	79.1	16	81.07*	11	76.2*	9
	Primary Care Physicians (Number per 100,000 population)	100.5	39	101.6	38	—	—	—	—
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	80.8	34	80.8	34	81.3	33	—	—
	ALL DETERMINANTS	3.6	23	2.2	26	5.6	19	5.9	14
HEALTH OUTCOMES									
	Poor Mental Health Days (Days in previous 30 days)	2.6	6	2.9	9	2.6	5	—	—
	Poor Physical Health Days (Days in previous 30 days)	3.1	9	3.0	6	2.6	3	—	—
	Geographic Disparity (Relative standard deviation)	10.6	25	11.0	30	—	—	—	—
	Infant Mortality (Deaths per 1,000 live births)	6.8	28	6.7	27	7.1	27	9.2	14
	Cardiovascular Deaths (Deaths per 100,000 population)	283.9	24	295.8	24	319.4	0	363.2	14
	Cancer Deaths (Deaths per 100,000 population)	191.3	22	190.7	18	188.1	10	175.1	8
	Premature Death (Years lost per 100,000 population)	7,277	23	7,236	24	7,079	22	7,581	14
	ALL HEALTH OUTCOMES	3.1	17	2.0	20	1.3	23	6.0	9
	OVERALL	6.7	22	4.1	23	8.3	20	11.9	11

⇓ and ⇑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

2009

Accountability

Joint Committee on Health Policy Oversight

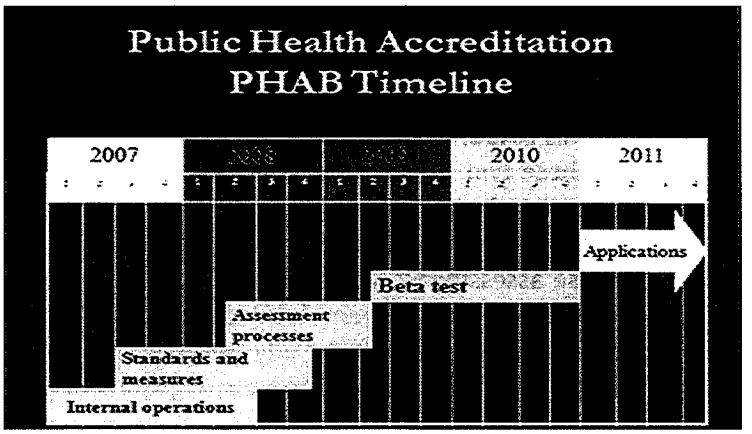
June 12, 2009

Kansas Public Health Long-Range Vision

Edie Snethen
KALHD
300 SW 8th Ave.
Topeka, Kansas
785-271-8391

1. National Public Health Accreditation is Coming in 2011

In order to improve the health of the public, the Public Health Accreditation Board (PHAB) is developing and implementing a national voluntary accreditation program for state, local, territorial and tribal public health departments. The goal of the accreditation program is to improve and protect the health of every community by advancing the quality and performance of public health departments. The accreditation program has been endorsed by the National Association of City and County Health Officials, the Association of State and Territorial Health Officers, as well as CDC.



Public Health Accreditation applies to both state and local health departments. It is voluntary. It is also acknowledged that in the future, accredited agencies may have better access to funding with the increased level of accountability associated with an accredited agency.

2. Implications for Public Health Accreditation in Kansas

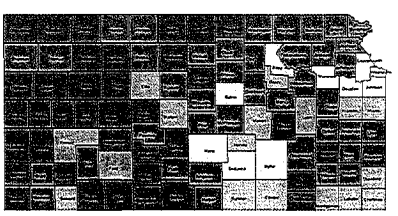
For the past two years, the Kansas Association of Local Health Departments has been working with our membership to understand the implications of accreditation and assist local health departments in positioning for accreditation.

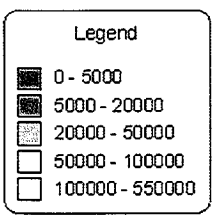
In taking on this effort, our membership has embraced the value:

"All residents of Kansas, no matter where they live, should be protected by a basic level of public health services"

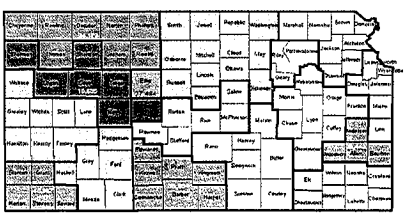
The set of standards that are being developed and vetted through a national review process, identify that basic level of public health services and accreditation provides the system of accountability.

National standards present challenges to rural states. A rule of thumb is that it takes a population of approximately 50,000 to support the array of public health services represented by the national standards. For this reason, KALHD has been actively engaged in developing regional cooperation options.





County Population
10 Counties with Population > 50,000



Public Health Regional Population
10 Regions with Population > 50,000
Smallest Region 20,000

In April 2009, the Kansas Association of Local Health Departments submitted comments to the Public Health Accreditation Board during the vetting of the draft accreditation standards. Our message from Kansas was **"Consider regions in local accreditation".**

KALHD

2009

Joint Committee on Health Policy Oversight

June 12, 2009

Kansas Public Health Long-Range Vision

Accreditation Efforts in Kansas

1. Positioning Local Health Departments for Accreditation

Because accreditation presents unique challenges to rural states and small health departments, the National Association of City and County Health Officials (NACCHO) received funding from the Robert Wood Johnson Foundation to look at regional approaches to accreditation. For this national study, Kansas and Massachusetts were selected for the pilot study.

Two public health regions (Northeast Corner Region and the North Central Region) participated in this NACCHO Regionalization Project. There are 21 counties and 19 local health departments in these two regions. Working with national consultants, each of the local health departments completed an assessment of their local capacity using an assessment instrument that was consistent with the standards being developed by the Public Health Accreditation Board. The results of these assessments were then compiled into regional reports. This process has given us a good picture of how current local public health capacity relates to the accreditation standards. Strengths and gaps were fairly consistent across agencies lending well to regional capacity development. Existing strengths were aligned with current funding priorities.

2. Engaging Local Elected Officials

In September 2008, the Kansas Association of Counties (with support from the Kansas Health Foundation) worked with KALHD to sponsor a Regionalization Summit that brought together local county commissioners and local health department directors to look at the issue of public health accreditation, its challenges for Kansas, and specifically looked at three structural models for Kansas communities to prepare for accreditation. Those structural models included:

1.) County health departments accredited individually
2.) Consolidation of county health departments
3.) Regional Cooperation as a strategy to strengthen local capacity in anticipation of meeting accreditation standards

KALHD continues to work with the Kansas Association of Counties to coordinate our efforts in accountability and accreditation with local county commissioners, who statutorily in Kansas are the Local Boards of Health.

3. Continuing Efforts

The second phase of the NACCHO Project was to identify key planning areas to address gaps identified through the assessment process. The priority areas identified through this process include:

Northeast Corner Region' s Planning Priority
Data issues need to support community health assessments and health improvement plans, program evaluation and quality improvement initiatives

North Central Region's Planning Priority
Communications

KAC/KALHD Summit Planning Priority
Public Health Financing

Additionally, the need to coordinate state and local preparations for accreditation was identified.

We continue to advocate for regional approaches to accreditation both here in Kansas and at the national level. In July at the National Association of County Officials (NACo) annual conference, a panel from Kansas will lead a discussion on Regional Cooperation: The Role of Local Elected Officials in Building Public Health Capacity. Panelists will include two county commissioners from Kansas, two representatives from KALHD, and a member of the NACCHO staff.

Edie Sneather
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Kansas Association of Local Health Departments
KALHD

2009

Proposed Public Health Planning

Joint Committee on Health Policy Oversight

June 12, 2009

Kansas Public Health Long-Range Vision

Edie Snethen
KALHD
300 SW 8th Ave.
Topeka, Kansas
785-271-8391

Proposed Planning Goals:

Develop a plan for building public health capacity that provides effective health protection across Kansas. The plan will include:

1. A common set of expectations for public health (aligned with final standards for accreditation of both state and local health departments)
2. Clarify responsibilities and functions for local and state public health (identify the handoffs between state and local, may differ with size of agency)
3. Increase accountability for public health through an accreditation framework
4. Facilitate coordination of public health services with community partners including safety net clinics

Proposed Planning Timeline:

June 12, 2009	Meeting with Health Policy Oversight Committee
June 2009	Submit Request for Financial Support to the Kansas Health Foundation
July 2009	Launch Steering Committee
	One year to complete plan
Summer of 2010	Steering Committee Provides Planning Report

Proposed Planning Structure

Steering Committee

Elaine Schwartz (KPHA), Jason Eberhart-Phillips (KDHE), Edie Snethen (KALHD) Co-chairs
KPHA Member Representative
KALHD Member Representative
Kansas Department of Health and Environment Representative
Kansas Health Institute Representative
Kansas Association of Counties Representative
University of Kansas Representative
Kansas Environmental Health Association Representative
Kansas Health Foundation Representative
(Participants to be named by above organizations)

Work Groups

The Steering Committee will appoint work groups to develop aspects of the plan and report to the Steering Committee. Three workgroups have been identified initially, recognizing the Steering Committee may identify additional areas of study through the course of the one year planning effort.

1. *Public Health Infrastructure Capacity Development* -using Public Health Accreditation Standards as the frame of reference
2. *Information Systems*– using data to support, target, and improve public health services
    a.) Support for community health assessments and targeting community needs through health improvement plans
    b.) Data to support quality improvement and accountability of public health services in Kansas
3. *Public Health Financing*

Kansas Association of Local Health Departments
KALHD

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KANSAS

Mark Parkinson, Governor
Roderick L. Bremby, Secretary

DEPARTMENT OF HEALTH
AND ENVIRONMENT

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Division of Health

Testimony to the Joint Committee on Health Policy Oversight

Jason Eberhart-Phillips, MD, MPH
State Health Officer and Director of Health, KDHE

June 12, 2009

My name is Jason Eberhart-Phillips, and for the past three months I have been the Kansas State Health Officer and Director of Health at KDHE. Thank you for the opportunity to speak with you today. My segment of this three-part presentation looks to the future, and to be honest the picture doesn't look good – unless we act.

Right now Kansas is in a high-speed car heading straight for a cliff. Health care spending, which already consumes one dollar in six produced by our economy, is keeping our foot on the accelerator and leading us straight to fiscal ruin. In the next 30 years runaway medical costs threaten to devour more than one-third of our state's gross domestic product. This financial burden is already damaging the global competitiveness of our farms and industries, while it is forcing tens of thousands of Kansas families into bankruptcy – even those with insurance. By a wide margin, uncontained health care spending is the single greatest threat to our state's balance sheet. It is the single biggest reason why businesses cannot invest what they should in research and development, why governments cannot adequately fund education, transportation, job training and other services that can grow our economy, and why wage growth has been virtually flat for a generation of middle-class Kansans. Wherever you sit on the political spectrum, whether you want to cut taxes, or increase spending, or simply make life a little easier for your hard-working constituents, the giant millstone of health care costs that hangs around the neck of this economy is sure to hold you back.

Bipartisan efforts are underway now in Washington to create new efficiencies in health care delivery, to reduce distorted incentives in the ways we pay for health care, to eliminate unnecessary duplication and to broaden coverage for every American. I wish them well, but to solve the problem of uncontrolled health care costs Kansas needs much more. We need to reduce the crushing demand for expensive medical services by preventing disease and injury in the first place, by making Kansas a healthier place to grow up, to work and to live. Only a strengthened public health system can do that. Only an active public health agency in each region of the state can work beside schools, businesses, health care providers and other local agencies to create the conditions that support optimal health and address disease risks at their root causes. Only a well-trained and well-managed public health workforce engaged at the local level can apply proven methods

- To prevent obesity, diabetes and other chronic diseases by improving access to healthy foods and increasing opportunities for physical activity,
- To interrupt the spread of communicable diseases like the novel H1N1 flu,

OFFICE OF THE DIRECTOR OF
CURTIS STATE OFFICE BUILDING, 1000 SW JACKSON S
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- To promote responsible sexual behavior,
- To keep kids away from addiction to tobacco, alcohol and other drugs, and
- To reduce the hazards that lead to serious injuries.

Treatment of diseases directly attributable to tobacco and obesity in Kansas – outcomes that are preventable through proven community-based programs – currently costs our state more than $1.5 billion each year. One recent study has shown that an investment of $10 per Kansan per year in public health programs aimed at improving nutrition, increasing physical activity and preventing tobacco use would save the state nearly $183 million in direct medical costs annually, while boosting the productivity of the workforce and improving the quality of life.

That's the money-saving power that could be unleashed by a strengthened public health system. And it's something your constituents say they want. A brand new poll shows that 70 percent of Americans rank greater investment in prevention and public health as a "very important" priority in health reform. Such investment is the only hope we have of slowing down that speeding car and getting Kansas back on the road to prosperity. This project aims to examine how we can create such a public health system in Kansas, and to return to you in one year with a specific plan that takes us there. Thank you for this opportunity to share with you this vision, and thank you in advance for your support of our objectives.

Together with Elaine and Edie, I would be happy to take your questions.

Report of the Kansas Health Information Exchange Commission to Governor Kathleen Sebelius

Executive Summary – 31 August, 2007

Introduction

Stakeholders in Kansas have worked collaboratively over the last two years to develop the infrastructure needed to support health information exchange (HIE) across Kansas and across state lines, with the State serving an integral role as convener and facilitator.

To further the work of the Kansas Statewide HIT/HIE Policy Initiative, Governor Kathleen Sebelius issued an Executive Order on February 7, 2007 establishing the Kansas Health Information Exchange Commission (the Commission) to serve as a leadership and advisory group for HIE in Kansas.

Over the past several months the Commission has identified several specific actions that support their charge from the Governor and the recommendations of the Kansas Statewide HIT/HIE Policy Initiative by addressing two key aspects of supporting and stimulating HIE on a state-wide level: **leadership** and **resource needs**.

Recommendations

Leadership Entity. A top priority of the Statewide HIT/HIE Policy Initiative and one of the primary recommendations from this initiative was the creation of a public/private Coordinating Entity to provide leadership to develop and support Kansas HIE activities. The HIE Commission validated this need for a public/private entity with existing and emerging HIEs as well as health care stakeholders in Kansas. The Commission examined governance structures for this type of public/private entity and evaluated three primary governance structures: 1) a public model which is government structured, managed and resourced; 2) a non-government, independent legal entity which is governed solely by private individuals and corporations; and 3) a non-government, independent legal entity which is a hybrid of options 1 and 2 and is governed by individuals representing both public and private entities and can be funded by public and private monies.

On August 16, 2007 the Commission met to compare these options based on the needs of HIE in Kansas, a review of successful models in other states, and feedback received from current HIE efforts across the state. The Commission unanimously recommends a hybrid of a private and public model as follows:

- Establish the Kansas Health Information Exchange Coordinating Entity (Coordinating Entity) as a not-for-profit, tax-exempt 501 (c) (3) corporation
- Appoint a governing board of up to 21 members consisting of 6 governmentally appointed members including at least one Kansas Health Policy Authority (KHPA) representative and up to 15 members from the following stakeholder groups/individuals:

KHIECE Exec. Dir. (ex-officio with vote)	Physicians
Consumers	Hospitals
Nurses	Public Health
Health Plans	Pharmacy
Laboratories / Medical Services	Long Term Care
Medical Practice Managers	Dental
Mental Health	Other healthcare entities (e.g. Quality Improvement Organization or Healthcare Foundations)
Employers	

- Existing HIE Commission would serve as an initial board
- Transition the existing HIE Commission initial board members to the final structure defined above by setting up staggered three-year terms (1/3 for one year, 1/3 for two year and 1/3 for three year terms)
- The governmental appointees could be selected by the Governor and Legislative leadership or designated by governmental office held
- The Board would appoint its own non-governmental replacements from the citizenry of the state using nominations from the organizations/associations representing stakeholders listed above
- The Board Chair would be elected by members of the Board for a 2 year term
- Criteria for appointment to the Board would include individuals representing entities using electronic data and HIEs as well as a passion and desire to improve the health of Kansans through the use of HIE.
- To support the activities of the Coordinating Entity, provide funding in year one of $485,287 (or $53,920 monthly for nine months of operation) and year two of $880,000.

Resource Support Services. An important priority identified by Kansas stakeholders has been to provide the resource support needed for HIE efforts across the state and the importance of fostering successful HIE at the local level. To address this priority, the Commission recommends that the first priority of the Coordinating Entity is to establish a mechanism or function for providing financial and non-financial resources to HIEs across the state. The function would be a central component of the statewide Coordinating Entity's responsibilities and would not be structured as a separate entity.

The Commission studied the approaches undertaken in other states to satisfy this need and constructed a model for support tailored to Kansas. The non-financial services would include: education (for consumers and HIEs as appropriate over time); standardization; legal and regulatory assistance (including privacy and security issues); guidelines and tools; contracting; subject matter expertise; a knowledge library; and metrics. Financially related services would include: determining priorities for community HIE funding; identifying potential projects to be funded; and developing eligibility requirements and selection criteria for the awarding of funds when funds are available.

Implementation

The recommended steps for establishing the Coordinating Entity are as follows:

- Constitute a 501 (c) (3), incorporated as the Coordinating Entity based on the governance recommendations above
- Establish a contract between the KHPA and the Coordinating Entity which is designed to fund the Coordinating Entity's activities, including the initial priority of delivering resource support services.
- Hire an Executive Director and one staff person to support the initial management of the Coordinating Entity
- Task the Executive Director to recommend a plan to the Coordinating Entity Board for providing the resource support services and other functions of the Coordinating Entity based on the approved budget. This recommendation should consider the direct hiring of staff within Coordinating Entity or contracting for staff and associated services from a third party entity.

The KHIE Commission appreciates the opportunity to offer these recommendations for leadership and resources and believes that the implementation of these actions will result in an important next step in supporting and stimulating HIE on a state-wide level in Kansas.

Report of the Kansas Health Information Exchange Commission

to

Governor Kathleen Sebelius

31 August, 2007

I. Overview

II. Scope of Responsibility
- Introduction
- Non-financial resource support
- Financial resource support

III. Organization and Governance

IV. Financial Sustainability

V. Milestones & Deliverables

VI. Resource requirements

VII. Budget range

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I. Overview

Stakeholders in Kansas have worked collaboratively over the last two years to begin developing the infrastructure to support health information exchange (HIE) across Kansas and across state lines with the State playing an integral role of convener and facilitator. The Governor's Health Care Cost Containment Commission began this process by convening the Kansas Statewide HIT/HIE Policy Initiative. This initiative brought stakeholders together to assess the capacity for HIE in Kansas and make recommendations to policy makers and health care leaders encouraging the adoption of health information technology (HIT) and HIE in order to improve the health of Kansans while ensuring privacy and security of personal health information.

This ongoing collaborative effort positioned Kansas well to receive two federal grants through RTI for the Health Information Security and Privacy Collaborative (HISPC) totaling more than $476,000 to date with the potential for additional funding in January 2008. The initiative resulted in a February 2007 report that made a number of key recommendations for building infrastructure in Kansas to support HIE.

To further the work of the Kansas Statewide HIT/HIE Policy Initiative, Governor Kathleen Sebelius issued an Executive Order on February 7, 2007 establishing the Kansas Health Information Exchange Commission (the Commission) to serve as a leadership and advisory group for HIE in Kansas. Over the past several months the Commission has identified several specific actions in response to their charge from the Governor and which expand on the recommendations of the Kansas Statewide HIT/HIE Policy Initiative by addressing leadership and resource needs designed to support and stimulate HIE on a state-wide level.

The Policy Initiative report recommended the establishment of a public/private coordinating entity to assume state-wide responsibilities for HIE over the long term. The report stated that this coordinating entity:

> "should facilitate collaboration and development of intra and inter-state HIE through education, provide technical assistance, serve as a resource center, foster pilot projects, and develop best practices."

To build upon that recommendation and to respond to the Governor's request for governance options for a public/private entity that would support HIE in Kansas, this proposal compares three options for a state-wide Kansas HIE Coordinating Entity (Coordinating Entity), with varying degrees of public and private involvement, and offers advantages and disadvantages of each.

An important priority identified by Kansas stakeholders has been to provide the resource support needed for HIE efforts across the state and the importance of fostering HIE at the local level. These functions will be a significant responsibility undertaken by the Coordinating Entity. Several innovative HIE initiatives are already underway in Kansas, and it is expected that additional initiatives will develop. While the needs of such initiatives which are in

11-4

a planning stage differ somewhat from those which are already beginning implementation, there clearly exists a need for an on-going resource to contribute to the success of HIE across the state, encourage coordination and communication across these efforts, and facilitate the adoption of HIT.

The Commission believes that the first priority of the Coordinating Entity should be to establish the capacity to provide financial and non-financial resources to HIEs across the state. The development of this capacity will be a central component of the statewide Coordinating Entity's function.

This document puts forth recommendations for establishing the Coordinating Entity by identifying options for its scope, organization and governance; milestones; resource requirements and budget for the first two years of operations.

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II. Scope of Responsibility

Introduction

The creation of the Coordinating Entity to further the work of the Commission, promote the public good, and support the immediate needs of health information exchanges (HIEs) across Kansas is deemed a first priority.

Some HIEs in Kansas are in search of guidance to advance their planning efforts, some are readying for implementation, and a small number have already begun exchanging data and are already expressing a need for coordination, collaboration, and assurance of interoperability. Those HIEs beginning the planning phase are in immediate need of tools, guidelines and subject matter expertise in the clinical, technical, financial, and governance aspects of HIE. Those HIEs which have committed resources beyond the planning phase require guidance on interoperability and financial sustainability. Inter- and intra-state challenges have emerged as issues for several geographically co-located HIEs, e.g., Kansas City metro area, Wichita. Those HIEs which are at the point of implementation or have already begun exchanging data require direction on how to address privacy and security issues, contracting requirements and education.

Beyond the specific requirements of Kansas HIEs, there is the need to address HIE issues among multiple stakeholder groups. These issues include the involvement of payers in providing claims data as well as considering changes to reimbursement mechanisms to promote the adoption of HIT; the incorporation of consumers in planning for security and privacy provisions of HIE in Kansas; the role of consumers in decisions related to the circumstances, individuals and breadth of personal health information to be exchanged; the involvement of employers/purchasers in providing economic support for HIE while receiving metrics upon which to judge the value of HIE; and the role of quality organizations facilitating the impact of HIE on improving care delivery.

At the same time, opportunities exist to coordinate state-based data bases and leverage existing infrastructure to ensure opportunities for community HIEs to collaborate with state agencies for potential public health or bio-surveillance purposes. At the national level, the development of Value Exchanges, Nationwide Health Information Network prototypes and additional funding for Privacy and Security necessitate participation and leadership by the Coordinating Entity to ensure Kansas is well positioned to take advantage of available funding and collaborative opportunities and to learn from these activities.

The aforementioned priorities can best be responded to by formalizing a state-wide Coordinating Entity and providing it the necessary funding to address these leadership based issues. The recommended steps for establishing the Coordinating Entity are as follows: First, create the legal structure for a Coordinating Entity based on the recommendations in Section III of this report. Second, establish a contract between the Kansas Health Policy Authority (KHPA) and the Coordinating Entity which is designed to enable the Coordinating Entity to carry out its duties and services. Third, retain an Executive Director and one staff support person for the Coordinating Entity or, in the alternative, contract for staff and associated services from a third party entity. Fourth, develop a plan for

11-6

the Coordinating Entity board to provide the services described based on the budget recommended in Section VII of this report. The plan should assure the Coordinating Entity's services are based on the "Scope" section of this document (Section II) to include developing tools, templates, standard contracts, recommended guidelines and other approaches to promoting HIE development in a consistent and cost-effective manner.

The services provided by the Coordinating Entity may be provided either directly or under a third party contract. They should be primarily focused on HIE and should be designed to support providers adopting or considering information technology in their individual care delivery settings. This support would be in the form of education, guidelines and standards related to interoperability and the role of technology to support the exchange of health information between systems.

In the course of finalizing the recommendations for the scope of Coordiating Entity services, the Commission invited one developing and three existing HIE efforts in Kansas to discuss the concept. The panel validated the scope described in this document as being directly in line with their needs both in terms of planning and implementing HIE initiatives. Some minor modifications were made to the planned financial and non-financial resources based on their input.

The following overview identifies the initial priorities for financial and non-financial support services to be provided by the Coordinating Entity either directly or through a third party contract with an existing, capable entity.

Non-Financial Resource Support

A. Education

The Coordinating Entity would oversee the development of a state-wide education plan to coordinate efforts across governmental and private entities as well as at the state and local levels and inform key stakeholders and policymakers, including consumers (starting small, incrementally addressing specific affected populations as appropriate), providers, employers, and payers about the importance of HIT and HIE in improving the delivery of health care as well as the overall health of the population. Recent developments in HIE across Kansas would be highlighted as examples. Additionally, the Coordinating Entity would conduct at least one statewide event annually to educate all operationally responsible stakeholders on HIT and HIE developments at the regional, state and national levels. The staff of the Coordinating Entity would support the data gathering and planning aspects of these education functions as well as develop template marketing and communications kits regarding the purpose and benefits of HIE that community HIEs could use to raise awareness among consumers and other stakeholders.

B. Standardization

The Coordinating Entity would ensure a standardized approach to

HIE across the state by developing common technical guidelines (based on national HIT and HIE standards), as well as finalize and adopt the HIE Guiding Principles developed by the Governance Workgroup of the Kansas Statewide HIT/HIE Policy Initiative. The support services provided would include regular communications to inform community HIE efforts on these topics as well as serve as a liaison between statewide and local HIE efforts. Additionally, to the extent that funding is provided to HIE efforts, the Coordinating Entity would make assessments of funded HIE's compliance with national standards and establish expectations for interoperability.

C. Legal and Regulatory Assistance

The Coordinating Entity would evaluate and recommend new laws and regulations, as well as changes to existing laws, on subjects related to HIE particularly in the areas of interoperability, privacy and security. The Coordinating Entity would provide assistance with interpreting legal statutes and regulations and, when appropriate, seek definitive interpretations from state and federal regulators. Particular focus should be given to the authorization and consent to access aspects of privacy and security of personal health information with an understanding of the consumer attitudes that will further guide these subjects.

D. Guidelines and Tools

The Coordinating Entity would develop a reference guide which provides guidance to those individuals and organizations undertaking the formation of a regional or local HIE. The Coordinating Entity should be knowledgeable and be able to direct inquiries to HIE sources available in the public domain. The Coordinating Entity would decide on membership in HIT and HIE organizations to ensure that their staffs and/or contractors are current on the latest developments and trends.

E. Contracting

Based on its priorities, the Coordinating Entity would develop recommended guidelines and templates for contracting with parties involved in providing the infrastructure for developing HIE as well as the stakeholders involved in sharing the data. This would include standard template contracts to use with software and hardware vendors as well as data sharing agreements such as Business Associate Agreements (BAA) for use with entities that generate and use the data expected to be exchanged.

F. Subject Matter Expertise

After obtaining periodic feedback on the specific areas in which community HIEs require external expertise, the Coordinating Entity would develop arrangements with consultants who are expert in specific areas of HIE to include governance, clinical, financial and technical aspects of HIE.

This approach would necessitate development of a definition of services that the Coordinating Entity would be willing to fund versus the costs that would be borne by individual HIEs for more tailored consulting services.

G. Knowledge Library

The Coordinating Entity would develop, maintain and make available a knowledge base of information to assist HIE projects across the state by collecting data and lessons learned from HIEs throughout Kansas and nationally. This would include a list of technology vendors which HIEs across the country are utilizing and the extent to which the vendors support national standards and certification requirements.

The knowledge library function would include the cataloguing of resources so that all stakeholders, especially consumers making inquiries about HIE can be provided sources of information and points of contact in their local communities.

H. Metrics

To assist in communicating the value of HIE, and for use with educational efforts, the Coordinating Entity would develop an approach for evaluating the return on investment (ROI) for HIE. This information could also be used by community HIE efforts in Kansas to substantiate the importance and value of HIE to local constituencies. This would include a methodology, tools and comparison benchmarks to determine the impact of HIE on the efficiency, quality and safety aspects of care delivery in comparison to the investment made by the community exchange.

I. Representation

The Coordinating Entity would decide on the extent of its representation at the state and national level and offer updates on national initiatives. It would also act as a forum for obtaining the input of Kansas HIE initiatives and communicate that input to national standard setting bodies.

The Coordinating Entity' leadership would take the lead on addressing issues related to communication and collaboration at the state and local level, including mediating conflicts between community HIEs in Kansas and among HIE's or other entities that are located outside the state. The staff would be focused on identifying common obstacles at the community HIE operational level and elevate issues to the Coordinating Entity's leadership as needed.

J. HIE Certification

The effectiveness of HIE is maximized when a threshold level of consistency and interoperability exists among individual efforts across the state. The Coordinating Entity would establish a certification process (or equivalent) for HIEs which sets forth specific expectations designed to promote both a level of commonality as well as ensure the eventual

exchange of data among community HIEs.

Financial Resource Support

A. Funding

To the extent that a portion of the budget of the Coordinating Entity includes direct financial support and funding of Kansas HIEs, specific initiatives designed to promote HIE need to be identified. The approach taken by other states, such as Michigan and Florida, has included funding of HIE development and implementation efforts at the community level. In a similar fashion, the Coordinating Entity could serve as a conduit for grants and contracts from a central funding source, such as state government through KHPA and foundations, to the community level HIEs. At this time the Coordinating Entity is not expected to have significant access to capital for these purposes during fiscal year ending June 30, 2008.

To determine priorities for funding, the Coordinating Entity should develop a process to identify the range of needs which exist among current and planned HIE initiatives across the state. A written survey instrument should be administered to identify the most common specific areas of need for community HIEs.

Consideration should be given to requiring community HIEs to match funding provided by the Coordinating Entity to ensure commitment of involved stakeholders and to allow funding to benefit the greatest number of initiatives.

B. Project Options

Options for project funding would be guided by parameters for HIE initiatives which are at their inception point and could benefit from seed funding as well as parameters for HIE initiatives which are beginning implementation. Based on the written survey, the Coordinating Entity might choose to fund one aspect of HIE which could then benefit multiple initiatives. Examples of such parameters include developing metrics for determining the impact of HIE on clinical quality, cost and satisfaction at different points in the delivery process from physician offices to hospital inpatient care to care provided in the post-acute setting. Another example is the development of metrics for assessing the impact of HIE on public health and community health functions. A third example includes developing best practices for governance, financial sustainability, contracting or privacy and security.

C. Eligibility Requirements and Selection Criteria

The Coordinating Entity should develop eligibility requirements and selection criteria for the awarding of funds to ensure HIE activities are in alignment with the goals of the Commission and the HIT/HIE Policy Initiative report.

III. Organization and Governance

The Commission validated the Statewide HIT/HIE Policy Initiative's recommendation to establish a public/private coordinating entity by considering three options: 1) a public model which is government structured, managed and resourced; 2) a non-government, independent legal entity which is governed solely by private individuals and corporations; and 3) a non-government, independent legal entity which is governed by individuals representing both public and private entities and funded by public and private entities.

Each of these options were considered based on the pros and cons of meeting four criteria for success: 1) financial sustainability; 2) ability of the Coordinating Entity to be responsive to community HIE needs; 3) the extent to which community HIEs would find the responsibilities and services of the Coordinating Entity to be of value; and 4) the ability of the Coordinating Entity to be effective in resolving HIE related conflicts and challenges (see Appendix A). The factors that influenced the evaluation of pros and cons for each option included issues related to: flexibility to raise and accept funding; reliance on multiple funding sources; ability to lobby; liability exposure; ability to focus on developing business cases for short and long term financial viability; ability to successfully coordinate with community HIEs and with state agencies; ability to demonstrate value; accountability and extent of influence by state government or legislature; level of bureaucracy; and ability to satisfactorily address the privacy and security of health information on behalf of Kansas citizens.

The vast majority of state HIE efforts nationwide that elect to form a legal entity and associated governance structure choose a legal structure which qualifies as a tax-exempt, charitable 501(c)(3) organization. Some states that are pursuing Medicaid Transformation grants elect to structure their HIE efforts as extensions of a state agency and become predominantly a public model as a result. The Commission's research did not identify any efforts that were solely state or public model in form aside from the Medicaid examples. In most cases, the extent to which the 501(c)(3) form is governed by state government is linked to the extent of state support, particularly as a source of funding. In some cases, the legislation which provides funding requires membership by state representatives on the board and specifically identifies the state offices or by title to hold board seats. As a result, statewide entities that choose the 501(c)(3) legal form vary in governance membership based on the environment, the extent of state support of HIE, and the level of involvement and support from other stakeholders. The research did not find any 501(c)(3) that had changed its legal entity status because of conflicts in mission or inability to provide services.

In addition to considering the examples from other states, feedback was solicited from a panel representing four HIE's in Kansas City and Wichita. The consensus was that the leadership and services of a state-wide HIE

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needed to be viewed as having the ability to act independently, yet not totally disconnected from state government.

Based on the comparison of options, the needs of HIE in Kansas, and feedback received from current HIE efforts across the state, the KHIE Commission recommends a hybrid of a pure private and public model similar to the legal form and governance which has been successful in other states to date.

The Commission therefore recommends the formation of a charitable 501(c)(3) tax-exempt entity with board membership as follows:

1. Board members serve staggered three year terms, with the exception of the initial board.

2. Year one – transition existing HIE Commission to Board of new entity (1/3 for one year, 1/3 for two year and 1/3 for three year terms) in addition to six governmentally appointed individuals; e.g. four individuals appointed by the Legislative leadership from both houses and each party and two individuals appointed by the Governor. The Commission recommends that at least one of the governmental appointments be from the Kansas Health Policy Authority (KHPA).

3. In subsequent years, the Board would appoint its own non-governmental replacements from the citizenry of the state using nominations from the HIE stakeholders of Kansas to include representation from as many of the following suggested stakeholder groups as possible:

- Consumers
- Physicians
- Nurses
- Hospitals
- Health Plans
- Public Health
- Laboratories / Medical Services
- Pharmacy
- Medical Practice Managers
- Long Term Care
- Mental Health
- Dental
- Employers
- Quality Improvement Organization
- Coordinating Entity Executive Director (ex-officio with vote)

4. Criteria for appointment to Board would include not just enthusiasm for HIE but also individuals representing entities with electronic data and HIEs as well as a passion and desire to improve the health care system.

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5. The Board make-up at the end of the three year transition period would be no more than 21 members, consisting of the 6 governmentally appointed members and up to 15 members from the stakeholder listing provided above. The Chair of the Board would be elected by the members of the Board for a two year term. Additional details are expected to be addressed during the crafting of by-laws for the entity.

IV. Financial Sustainability

A. Initial Funding

Funding of the Coordinating Entity's first year of operations is expected to be provided by the State of Kansas through the KHPA. The budget provided in Section VII of this report is for the first year of operations (balance of this year through June 30, 2008) and for the second year of operations (July 1, 2008 through June 30, 2009). It represents the costs for constituting the Coordinating Entity and providing services and is modeled on the costs of similar initiatives in other states. The total dollars available for the Coordinating Entity's operations for year one is pending clarification from KHPA.

B. Sustainability

The Coordinating Entity will need to develop a multi-year funding plan to sustain operating costs after year one. This plan should be based on the value provided by the Coordinating Entity in the first year of operation and an understanding of the expected needs of HIEs across Kansas. The plan to sustain operations should consider the following funding options:

- Continued funding from the State of Kansas through the KHPA
- Integration with other community efforts such as Economic Development
- Funding by community HIE initiatives based on a subscription, use or other economic model
- Applying for federal, foundation or other philanthropic grant funding independently or in conjunction with other state agencies and other state or community HIE initiatives
- A legislatively driven approach to raising revenue, such as a tax

V. Milestones & Deliverables

The following table provides the specific milestones and associated deliverables to be accomplished in developing its services.

Milestone	Deliverable
KHIE Commission submits recommendations for the establishment of the Coordinating Entity to the Governor	
Governor approval of Coordinating Entity formation	Communication to KHPA from the Governor approving the formation of the Coordinating Entity, specifying that funds be made available to establish the Coordinating Entity as a legal entity and that a contract be established between KHPA and the Coordinating Entity for funding
Incorporation of Coordinating Entity	By-laws, Incorporation Filing, Tax-exemption application
Appointment of Board members	HIE Commissioners plus 6 governmental appointees as initial board
Initial Year funding	Contract with KHPA
Coordinating Entity initial staffing	Hire an Executive Director and one support staff
Coordinating Entity decides on hiring additional staff directly or contracting with a third party for selected services	Recommended plan by Executive Director and either subsequent hiring as Coordinating Entity staff or issuance of a RFP and subsequent contracting for staff and services
Develop FY09 Budget	Executive Director develops and recommends to Coordinating Entity
Budget approval	Coordinating Entity submits FY09 budget to KHPA and the Governor

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Milestone	Deliverable
Coordinating Entity Schedule and Activities	Periodic meetings, decision making processes, selection of Chair, and any necessary licenses/permits
Develop Measures for HIE in Kansas	Short term Measures: • HIE Participation • Quantity of Technical Assistance provided Long Term Measures: • Design Safety measures • Design Quality measures • Design Efficiency measures
Create Communication Plan	Consumer Communications Plan Provider Communication Plan
Establish Stakeholder Coordination	Monthly Reporting to the Coordinating Entity Design Stakeholder feedback approach Deploy stakeholder feedback
Deploy Training and Education programs	Design Training and Education programs Plan for deployment Pilot deployment Full scale deployment Measurement of impact/attendee satisfaction
Develop Convening Mechanisms (conference/web mtgs., etc.)	Design convening approach Deploy quarterly formal HIE conferences/web meetings

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Milestone	Deliverable
Develop coordination strategies for complementary activities in state (TeleHealth, Economic Development, state activities, Public Health, Homeland Security/ State Infrastructure, Disaster Recovery, First Responders, EMR adoption by HC Providers, etc.)	Plan for coordination with complementary initiatives
Monitor and Support Kansas HIE's Needs for Assistance	Define Assistance areas of focus • Security & Privacy • Business Planning • Information Technology 1. Standards 2. Architecture Models 3. Connectivity 4. Applications for HIEs • Procurement • Governance • Clinical and Workflow Change Management • Quality of Care • Consumer Engagement • Measurement Methodology
Establish Kansas specific HIE Library	Survey library needs Consider coordination with complementary activities in neighboring states Design library approach Implement library Measure impact

VI. Resource Requirements

The personnel staffing needed to support the responsibilities of the Coordinating Entity and the services that are to be provided fall into four categories of expertise and duties: leadership, project management, support staff and subject matter expertise. Should the Coordinating Entity decide to

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contract for selected services, the potential contracted entities would delineate their approach to project management, support staff and subject matter expertise in formal proposal responses to an RFP.

Leadership should be provided by one full-time individual who has responsibility for the overall operational and financial management of the Coordinating Entity. This includes but is not limited to: implementing the priorities of the Coordinating Entity board of directors; developing a plan for the necessary services to be provided directly or through contract; developing budget requirements and securing the necessary funding for future years; identifying major HIE challenges and opportunities as well as providing regular updates to the Coordinating Entity board, KHPA, the legislature, the Governor's office and others; representing the State of Kansas in regional and national forums; and serving as a point of contact for intra and inter-state HIE activities and issues. This position should report to the Coordinating Entity board of directors and be a full-time employee of the Coordinating Entity as opposed to a contract employee.

The contract between the Coordinating Entity and the KHPA would include annual funding and address the relationship and level of accountability expected between the Coordinating Entity and the KHPA as well as between the Coordinating Entity and the Governor of Kansas.

Project management should be provided by one project manager and two business analysts. These individuals would be responsible for working with community HIEs on a day to day basis to perform analyses, solve operational problems, implement projects and communicate priorities and needs to partners. Full staffing is expected to develop over time in response to needs.

Support staff should consist of one administrative assistant with responsibility for supporting the leadership, project management staff and the Coordinating Entity.

The provision of subject matter experts should be based on the collective priority needs of community HIEs. The Executive Director should have responsibility for identifying, quantifying and recommending priorities to the Coordinating Entity body. The selection of subject matter experts should follow a formal process and the retention of consultants should be structured on the basis of defined scope and deliverables.

In addition to staffing, resource requirements for facilities space, logistics, legal fees, and administrative and other costs are identified in section VII.

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VII. Budget Range

CATEGORY	DIRECT COST RANGE	BENEFITS	July 2007 – June 2008 BUDGET	July 2008 - June 2009 BUDGET
Executive Dir	$100-200k	$34,500	$150k	$156k
Project Mgr	$70-90k	$18,400		$85k
Bus Analyst 1	$50-70k	$13,500	$60k	$62.4k
Bus Analyst 2	$40-60k	$10,350		$47.7k
Admin Assist	$30-40k	$8,050	$35k	$37,1k
Consulting	$200-300k	n/a	$250k	$300k
Facilities	$34,000	n/a	$34k	$34k,
Insurance	$5k	n/a	$5k	$5k
Legal	$20-30k	n/a	$25k	$30k
Prof education	$5k	n/a	$5k	$5k
Travel	$15-30k	n/a	$20k	$25k
Office costs	$5-8k	n/a	$7k	$8k
Sub-total		$56,050	$591,000	$795,200
TOTAL			$647,050	$880,000
Assuming 9 months of operation in the first fiscal year. Each additional month of operations would require an additional $53,920.00			$485,287	

Budget Assumptions:

- Initial budget should be allocated based on number of months in existence between July 2007and June 2008
- Initial staffing is limited to align with start-up operation
- benefits computed at 23%
- salary increase computed at 4%
- facilities computed for 2,000 sq ft at rate of $ 17.00 per square foot
- Consulting is a factor of the assistance provided by the contractor to Kansas HIEs during planning and implementation phases and includes the functional aspects of governance, clinical, technology, financial, legal and security/privacy. The legal fees for costs associated with establishing the Coordinating Entity and the contracts are budgeted separately as "legal".

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Appendix A
Governance Model Summary

The following table summarizes the key success factors to be considered when the Commission determined the governance path for directing the activities of the Coordinating Entity.

Three types of governance models are compared with the pros and cons of each described in the following table. Each of these models is designed to represent a generic form of legal entity and governance. Because the three categories of governance models (public, private, and hybrid) are points on a continuum of potential structures, the three examples below are provided to distinguish the three options considered. It should be acknowledged that no true completely public model was identified in the research, other than in states that are pursuing HIE in support of Medicaid based initiatives such as Transformation Grant opportunities. Additionally, the private models tended to not be completely private from a governance standpoint. The hybrid is an example of the variation in governance that HIEs assume based on factors such as the state environment, funding and the scope of responsibilities and duties of its mission.

Example One is a public model representing a government structured, managed and funded entity. The closest example available is the Delaware state-wide HIE, the Delaware Health Information Network (DHIN), which was created by an act of the General Assembly and signed into law in 1997 as a public instrumentality of the state to advance the creation of the statewide health information and electronic data interchange network for public and private use. The DHIN organization falls under the purview of the Delaware Health Care Commission. DHIN is a public/private partnership that provides the organizational infrastructure to support a clinical information sharing utility. The development of the clinical information sharing utility is the primary focus of DHIN at this time. This entity has access to funds through state bonds.

Example Two is a private model which represents a non-government, independent legal entity which is governed and funded by private individuals and corporations. CalRHIO, the state-wide HIE for California is an example which comes closest to the private model. CalRHIO was formed in 2005 as a collaborative statewide initiative whose mission is to improve the safety, quality and efficiency of health care through the use of information technology and the secure exchange of health information. The organization is in the process of raising $300 million. During the period 1/05 – 4/07 its funding was provided by federal grant (7%); foundations (42%); hospitals (26%); health plans (22%) and other (3%). CalRHIO is governed by a 21 person board, of which 4 ex-officio members are representatives of the state or governmental programs.

Example Three is a hybrid of the public and private models and constitutes a non-government, independent legal entity which is governed by individuals representing both public and private entities and can be funded by public and private individuals and organizations. An example of the hybrid

model is Vermont Information Technology Leaders (VITL). VITL is a non-profit, public-private partnership formed in 2005 with the vision of sharing real-time clinical information among health care providers across the state, improve patient outcomes while reducing service duplication, and decreasing the rate at which healthcare spending occurs. The majority of seed funding was provided by the state legislature as part of its healthcare reform efforts and the legislation included specific requirements to include the appointment of four (4) state agency commissioners to the board as well as the requirement that VITL develop the long term HIE plan for the entire state. The state has continued its funding support of VITL in two ways: the continued direct support of its HIE activities; and secondly, through a significant, multi-million dollar contract for services to the Department of Health to provide the infrastructure to support a chronic care information system. The Vermont Health and Hospitals Association provided seed funds and has continued to support VITL through annual disproportionate share funds. As a result, current revenue and funding includes: legislated support; state contracts for services; transaction fees; hospital association funds; and federal grants (HISPC). The board is composed of 20 individuals representing payers, providers, trade associations, employers, government, consumers and quality organizations. There are seven (7) state or federal affiliated members of the board which include: five (5) state employees to include four (4) commissioners; one member is the QIO for the region; and one member represents the VA hospital.

SUCCESS FACTORS	PUBLIC MODEL	PRIVATE MODEL	HYBRID MODEL
Financially sustainable: **PRO**	• Funding has potential to be linked to other projects/issues • Some options for obtaining grant funding • Some reduction in liability exposure	• Business model not dependent on state funding priorities • Depending on legal structure, greater opportunity for receiving grant and other funding	• Business model not dependent on any one source for revenue or funding • Significant flexibility for receiving grant and/or philanthropic funding from public and private sources

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SUCCESS FACTORS	PUBLIC MODEL	PRIVATE MODEL	HYBRID MODEL
Financially sustainable: **CON**	• At discretion of state/legislative priorities • Requires annual commitment of state funds • Limited reliance on other funding options	• Requires demonstration of value from funding sources • Need for seed funding source • Need to develop business case for long term viability with identified resources • Members of governance assume fiduciary responsibility	• Requires demonstration of value from funding sources • Need to develop business case for short and long term viability • Members of governance assume responsibility for financial planning

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SUCCESS FACTORS	PUBLIC MODEL	PRIVATE MODEL	HYBRID MODEL
Responsive to Community HIEs: **PRO**	• Potential higher assurance of sustainability may drive resource ability to be responsive • As component of existing state agency, improved ability to coordinate with other state entities • Responsive to the needs of legislature and other state policymakers • Accountability to the State	• High level of responsiveness to community HIE needs • Priorities driven by stakeholder consensus • Not dependent on state accountability or processes/rules • Accountability to independent governance entity • Can recommend legislative actions – specific lobbying strategy and tactics vary	• High level of responsivenes s to community HIE needs • Priorities driven by stakeholder consensus • Accountable to state based on governance representation and contractual obligations for use of funding • Can recommend legislative actions – specific lobbying strategy and tactics vary • Priorities driven by governing body and need for sustainability
Responsive to Community HIEs: **CON**	• Priorities may be driven by state agencies • Bureaucracy may thwart high level of responsiveness	• Priorities could be driven by dominant or advanced HIE stakeholders, rather than consensus	• Lobby activity is more limited and is dependent on stakeholder organizations

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SUCCESS FACTORS	PUBLIC MODEL	PRIVATE MODEL	HYBRID MODEL
Community HIE interest in using services: **PRO**	• Ability to work with other state entities • Accountability to state/legislature could enhance legislation (i.e. privacy and security)	• Independence perceived positively • Accountability to stakeholders perceived positively	• Independence perceived positively • Accountability to stakeholders perceived positively
Community HIE interest in using services: **CON**	• Poor experience with similar models (Delaware was slow) • Perception of state-driven priorities/agenda could deter focus from HIE	• Lack of demonstrated value could result in attrition, lack of use and funding shortfalls • Focus of services could be different for community HIEs based on stage of development and needs • Limited experience in other states (CalRHIO still has limited state involvement)	• Lack of demonstrated value could result in lack of support from private and public entities • Focus of services needs to be responsive to mission and designed to support a business • Successful model in other states (VT, MI, MA, WI)

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SUCCESS FACTORS	PUBLIC MODEL	PRIVATE MODEL	HYBRID MODEL
Ability to resolve HIE related conflicts: **PRO**	• As a state entity, advantage dealing with other states and across agencies • Ability to recommend legislatively driven resolution • Ability to understand conflicts involving other state entities • Transparency in dealing with consumer issues due to government funding • Ability to address privacy and security issues on behalf of patient consumers	• Ability to act independently of external influences • Ability to seek resolution for HIE reasons and not unrelated issues (political issues?) • Ability to represent patient consumer on security and privacy issues	• Through governance and/or funding, connectivity to a state agency can be beneficial • Ability to act independent of external influences (excluding contractual obligations) • Ability to represent level of independence to consumers on privacy and security issues
Ability to resolve HIE related conflicts: **CON**	• May appear to take the 'state's position' on resolving conflicts	• Lack of political power/influence of a state entity • Recommendations and actions may not align with expectations of state agencies	• Lack of direct political power/influence of a state entity • Lobbying activity limited • Recommendations and actions may not align with expectations of state agencies

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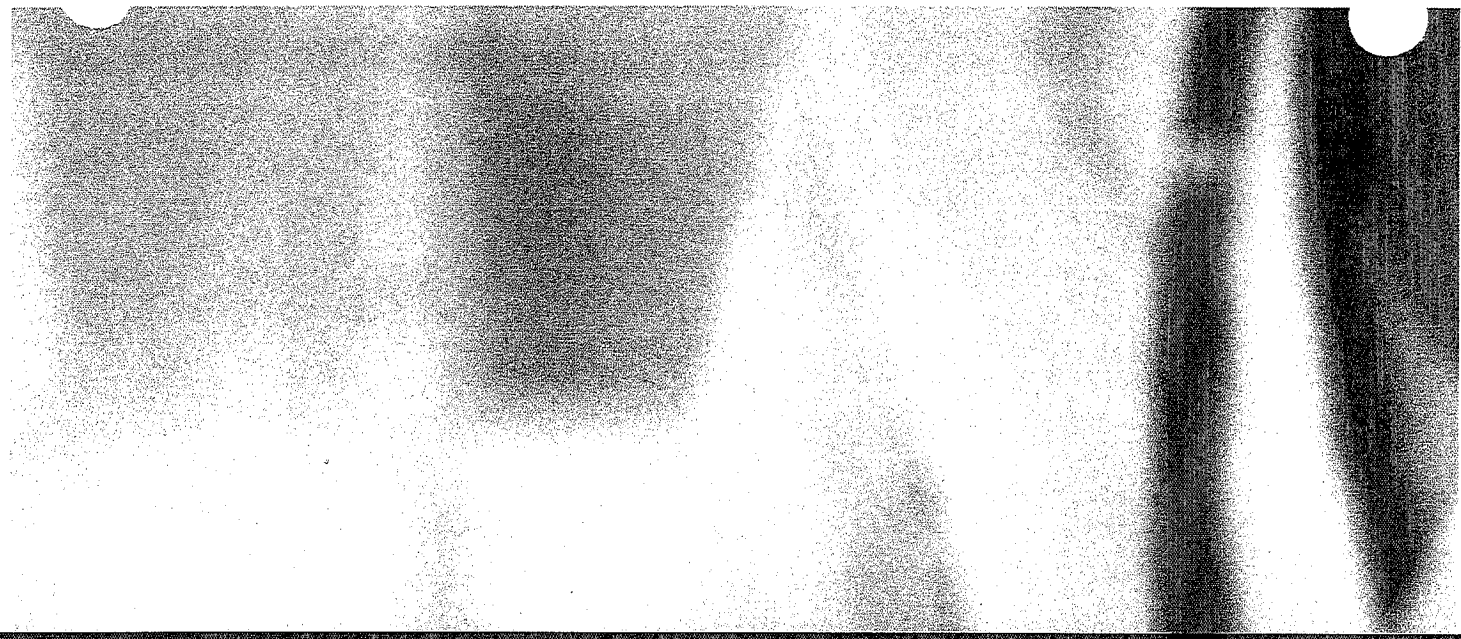

Kansas Health Information Technology/ Health Information Exchange Policy Initiative

FEBRUARY 2007

Joint Committee on Health Policy Oversight
6/12/09
Attachment 12

Kansas Health Information Technology/Health Information Exchange Policy Initiative

PROJECT MANAGEMENT

Kansas Health Policy Authority

Karen Braman

Chase H. Finnell

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PROJECT FACILITATION

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John K. Evans

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Andrew Weniger

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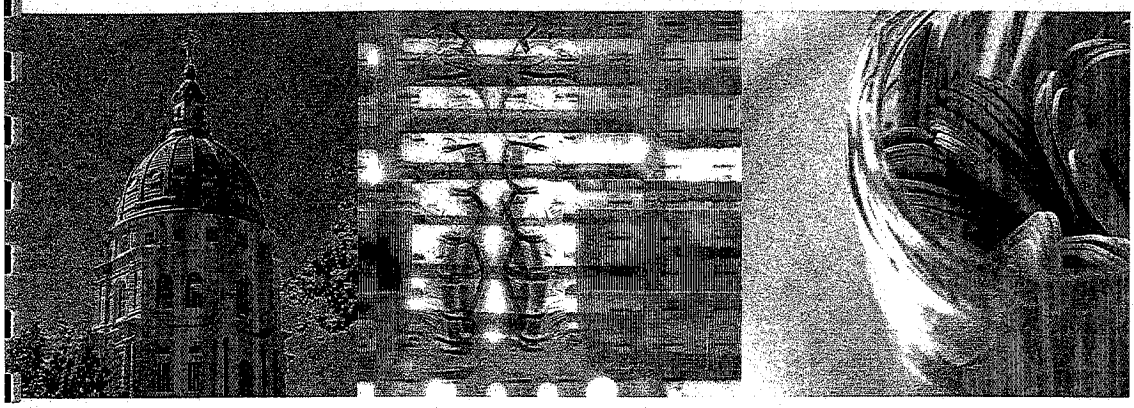

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Kansas HIT/HIE Policy Initiative

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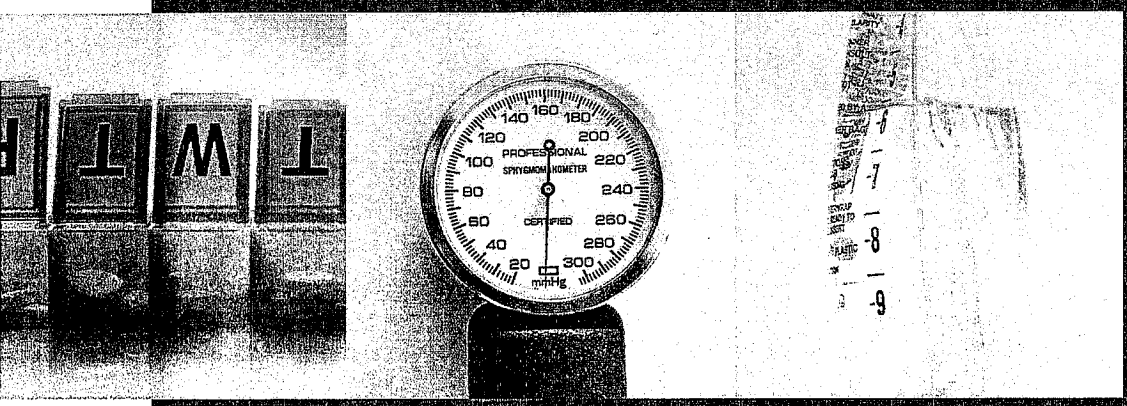

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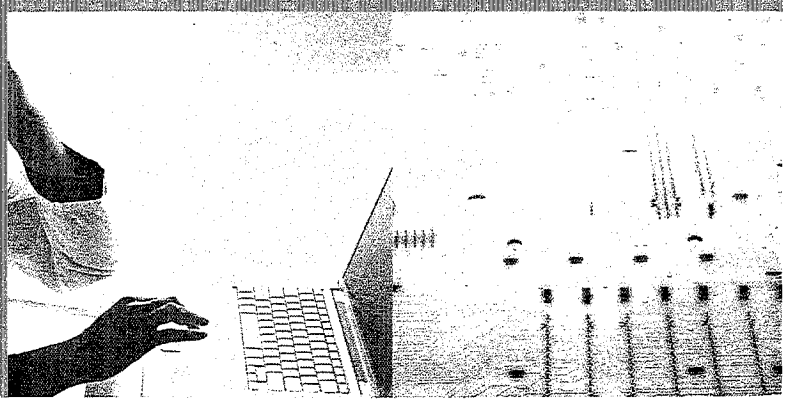
Executive Summary

Over the past several years the Federal government and a number of states have begun devoting increased attention to the impact that timely and accurate health information can have on improving the quality, safety, and cost-effectiveness of the health care delivery system. The State of Kansas has assumed a leadership role among states across the country in developing plans to use health information technology and the exchange of health data to achieve these improvements.

Beginning in the Fall of 2005, efforts were initiated by Governor Kathleen Sebelius and key stakeholders across Kansas to develop a vision and initial strategy promoting the adoption of health information technology (HIT) and health information exchange (HIE). Funding for the HIT/HIE Policy Initiative was provided by the Sunflower Foundation, the United Methodist Health Ministry Fund, the Kansas Health Foundation, and the Kansas Health Policy Authority.

Since that time, significant progress has been made with contributions from Kansas health care leaders across the state on developing infrastructure that will enable health information exchange in our state. This statewide effort resulted in specific recommendations regarding clinical, financial, technical, privacy and security, and governance aspects of health information exchange. Seven core recommendations were developed to drive the implementation of an HIT and HIE plan for the State of Kansas. Each recommendation includes a series of explicit actionable steps.



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01 ESTABLISH A LEADERSHIP GROUP

There is a need to maintain the momentum established over the past year and begin implementing recommendations developed as a result of the statewide Initiative. This group should focus on broad policy issues surrounding HIE, create the most appropriate mechanisms for advancing HIE in Kansas, and promote the public good by ensuring an equitable and ethical approach to the use of private and secure health information.

02 CREATE A PUBLIC/PRIVATE ENTITY TO ADVANCE HIE OVER THE LONG-TERM

To further the work of the Leadership Group over the long term, a public/private not-for-profit entity should be established to assume responsibility for HIE activities on a statewide basis. This public/private Coordinating Entity should facilitate collaboration and development of intra- and inter-state HIE through education, provide technical assistance, serve as a resource center, foster pilot projects, and develop best practices.

03 PROVIDE EDUCATION TO ALL STAKEHOLDERS REGARDING HIT AND HIE

Developing communication and education based on common HIT and HIE terminology is requisite for public understanding and acceptance of HIE, formulation of public policy, and sustainable financing. Additionally, further development of an IT savvy workforce and building physician leadership across the state are critical to the adoption of HIT and HIE.

04 LEVERAGE EXISTING RESOURCES AND EXISTING DATA SOURCES

A number of resources exist in Kansas that exchange health information, finance the exchange, of health information or benefit from the exchange of health information. Coordination of HIE across state agencies, collaboration with entities addressing the same issues surrounding HIE, and aligning incentives to foster HIT and HIE are necessary to ultimately have the desired impact of improving health care quality, safety, and cost-effectiveness. The Kan-Ed network can be built upon to further the infrastructure needs of many health care providers across the state, especially in rural areas. At the same time, a number of public and private HIE initiatives in Kansas are already underway and should be leveraged as building blocks for HIE. Some of these include: Healthe Mid America, Kansas City Regional Electronic Exchange (KCREE), KC Care Link, the Medicaid Community Health Record Pilot, and the state's Immunization Registry.

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05 DEMONSTRATE THE IMPACT OF HIE

To foster the adoption of HIT and interoperable exchange of health information, it is imperative that its value and impact on the health care system be demonstrated to many audiences. This includes quantifying the impact of HIE on all aspects of the health care system. Patients and consumers need to understand that their individual health information will be kept private and secure, and that sharing this information can improve their care. Providers need to know the impact not only on quality and safety, but also on their workflow and finances as. Employers and payers need to understand the value of HIE in reducing cost and promoting efficiency.

06 RESOLVE PRIVACY AND SECURITY BARRIERS ASSOCIATED WITH HIE

Personal health information must be kept private and secure, and individuals must be able to control their own information and who has access to it. A series of patient, business, legal, and regionally focused solutions are recommended here that address barriers to health information exchange and preserve privacy and security.

07 SEEK FUNDING FROM MULTIPLE SOURCES

Developing HIEs should seek seed funding from a variety of sources. The public/private Coordinating Entity and/or Resource Center can assist with the identification of available funding and/or the provision of grant funds to catalyze HIE. Consideration should be given to the development of an investment fund that can be used to fund innovations in HIE.

This report, intended to be a resource for policymakers and state leaders, represents a compilation of strategies and specific actions recommended by Kansas health care stakeholders who have worked diligently over the last six months to develop a plan to advance HIE while ensuring patient privacy and security.

"Health information technology and information exchange can greatly improve the quality and safety of our health care system. We must work together to foster the use of technology to improve health care and ensure that individuals' health information is kept private and secure."

Governor Kathleen Sebelius

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02

Health Information Exchange (HIE) reflects the infrastructure to enable data sharing between organizations. Services are built once and used multiple times by many. Items such as a central Web site, health care terminology translation tools, a Master Patient Index, authentication and authorization infrastructure, and applications to aggregate information from multiple sources are examples of HIE resources.

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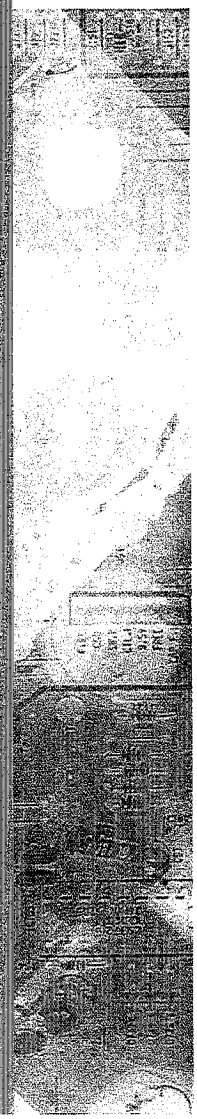
Introduction

The use of health information technology (HIT) and health information exchange (HIE) to transform the health care system has been a top agenda item nationally and locally for several years. Consensus has emerged that HIT and HIE, when implemented properly, can improve the quality, safety, and efficiency of health care. Kansas, like many other states, has begun a dialogue with health care stakeholders on how best to promote the adoption of HIT and foster HIE for the betterment of the health care system. This document reflects the thinking of Kansas leaders in health care, business, government, and advocacy on how to develop an infrastructure to support HIE in Kansas that will lead to better patient care and a more efficient health care system.



Health Information Technology (HIT) is the local deployment of technology to support organizational business and clinical requirements. HIT is technology implemented within the physical space of a doctor's office, laboratory and hospital or virtually through a hospital system. Items such as Electronic Medical Records (EMR) systems, administrative systems (such as billing), and workflow systems are examples of HIT systems.

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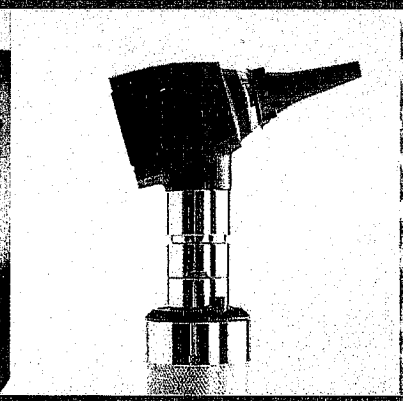
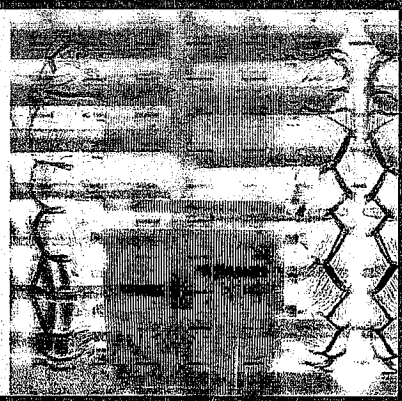
03





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Background

In November 2004, Governor Kathleen Sebelius announced the Healthy Kansas Initiative, a continuation of the health reform agenda she began as Insurance Commissioner. The most significant component of the Healthy Kansas Initiative was streamlining state health care purchasing which led to the creation of the Kansas Health Policy Authority. Another component of Governor Sebelius' health care reform was to address the problem of soaring health care costs system-wide, through the creation of the Kansas Health Care Cost Containment Commission (H4C). The Commission, chaired by former Lieutenant Governor John Moore, was charged with focusing on ways to improve the quality, safety, and cost-effectiveness of health care. Not surprisingly, the H4C identified HIT and HIE as most promising to improve the health care system and commissioned the HIT/HIE Policy Initiative.

We thank the following organizations for their generous support of the Kansas statewide HIT/HIE Policy Initiative:

Sunflower Foundation, United Methodist Health Ministry Fund, Kansas Health Foundation, and the Kansas Health Policy Authority for project funding.

We are grateful for the leadership of former Lieutenant Governor John Moore.

A special thanks to the participating stakeholders for their time and dedication to this project for more than a year, especially the Workgroup leaders:

Howard Rodenberg, Kansas Department of Health and Environment
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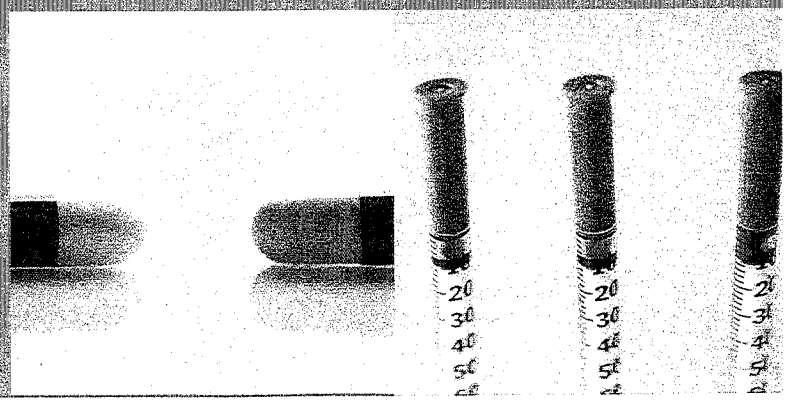
Diana Hilburn, Via-Christi Health System
Robert St. Peter, Kansas Health Institute
Helen Connors, Ph.D., Executive Director, KU Center for Healthcare Informatics
Bill Bruning, Mid-America Coalition on Healthcare
Jeff Ellis, Lathrop and Gage
Ron Liebman, Kansas Health Institute
Judy Warren, KU Center for Healthcare Informatics



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PHASE 1
Kansas HIT/HIE Policy Initiative History

The purpose of the Initiative's first phase was to perform an initial assessment of HIT and HIE capacity in Kansas, develop a shared vision with Kansas stakeholders for the adoption of HIT and interoperable HIE, and develop key principles and actions for an e-health information strategy in Kansas.

KEY EVENTS AND ACTIVITIES THAT OCCURRED DURING THE FIRST PHASE OF THE PROJECT

Summer 2005

Kansas Hospital Association (KHA) Electronic Health Record Working Group - The Electronic Health Record (EHR) Working Group, originally convened to develop guidance for provider organizations implementing HIT, developed several recommendations that were incorporated into the statewide HIT/HIE initiative undertaken by the H4C. These recommendations include:

- Establish a mission/vision for a statewide strategy
- Develop an independent, collaborative governance model
- Develop sustainable funding and resources
- Follow common definitions and standards to allow for interoperability and information exchange
- Promote privacy and security while pursuing the organizational mission
- Facilitate HIT/HIE with an open architecture and secure environment

Fall 2005

H4C commissioned the Kansas HIT/HIE Policy Initiative - Performed an initial assessment of HIT and HIE in Kansas via interviews with Kansas health care leaders, developed a shared vision for the adoption of HIT and interoperability in Kansas, and created key principles and high level actions for a statewide e-health information strategy in a briefing paper.

12-12

Fall 2005

Kansas Stakeholder Interviews - Health care leaders from hospitals, physician practices, health plans, employers, academic medical centers, advocacy groups, and government were interviewed about the current status of HIT implementation and HIE in Kansas, HIT's potential to address the state's health care challenges, and actions needed to move the state toward broader adoption of HIT and HIE. These interviews confirmed that HIT and HIE are increasingly viewed as important tools to address the health care challenges the state faces. Major themes from the interviews included:

- Support for the development of independent regional networks across the state that are coordinated and connected
- Belief that the State could serve in a leadership capacity by facilitating, coordinating, and convening stakeholder groups and support for a public/private approach
- Strong support for the Governor's and Lt. Governor's efforts to increase the priority and visibility of HIT and HIE
- Emphasis on Kansas' rural areas, especially rural hospitals and small independent physician practices in any exchange effort (over 79 percent of the community hospitals in Kansas are located in a rural setting, compared to less than 44 percent of hospitals on a national level.[1]
- Barriers identified include: lack of interoperability standards, financing, and stakeholder understanding and knowledge of HIT/HIE privacy and security

12-13

1 Kansas Hospital Association, 2004 Annual Stat Report

January 27, 2006

Wichita, Kansas Statewide Stakeholder Meeting - Approximately 60 stakeholders from across the Kansas health care community developed a shared understanding of national and Kansas HIE activity and began creating a statewide HIE strategy. The briefing paper outlining an initial assessment of HIT and HIE activities in Kansas and capturing Kansans' perspectives on HIT and HIE was distributed.[2]

February 16, 2006

Topeka, Kansas HIE Steering Committee Meeting – The HIE Steering Committee of the H4C, composed of a diverse group of stakeholders, assembled to create draft vision, values, and guiding principles; examine potential first-year projects; discuss governance models; and begin developing methodology to prioritize future HIE efforts.

March 1, 2006

The Health Information Security and Privacy Collaboration (HISPC) - The H4C, in partnership with the Kansas Health Institute, the University of Kansas Center for Healthcare Informatics, the Mid-America Coalition on Healthcare, and Lathrop & Gage submitted a proposal in response to the Federal Department of Health and Human Services' request for proposals through RTI International and the National Governor's Association and was awarded a contract for over $305,000. Kansas is one of 33 states and Puerto Rico awarded contracts as part of the national HISPC contract through the Agency for Healthcare Research and Quality. The purpose of the project is to assess business practices and policies associated with the exchange of health information and develop solutions to potential barriers.

March 6, 2006

Topeka, Kansas HIE Steering Committee Meeting - The HIE Steering Committee of the H4C finalized the vision, values, and guiding principles drafted at the Feb. 16, 2006 meeting, completed the methodology for prioritizing future HIE projects, and established an agenda for the March 23, 2006 statewide stakeholder meeting.

March 23, 2006

Topeka, Kansas Statewide Stakeholder Meeting - Achieved consensus on vision, values, and guiding principles for an HIE infrastructure in Kansas. Attendees discussed and provided feedback on future HIE projects; volunteered to participate in HIE Working Groups; and defined success for Phase 2. This meeting culminated in the launch of Phase 2 of the Kansas HIT/HIE Policy Initiative, which included the creation of multi-stakeholder Workgroups.

PHASE 2
Kansas HIT/HIE Policy Initiative Workgroups

The need to foster the adoption rate of HIT and the implementation of HIE in Kansas was established during the first phase of the Kansas HIT/HIE Policy Initiative. Building upon consensus achieved during two statewide stakeholder meetings in January and March 2006, Kansas decided to undertake phase 2 of the Initiative.

The second phase of the Kansas HIT/HIE Policy Initiative involved an intensive 180 day Workgroup process launched in summer 2006. The goal of this process was to determine governance roles and structure; and to further the implementation and coordination of regional and statewide HIE projects in Kansas. Five multi-stakeholder Workgroups were created, including Clinical, Technical, Finance, Governance, and Privacy and Security. Privacy and Security was handled through the HISPC subcontract. The Workgroups had broad stakeholder participation that was inclusive and provided a means for all interested individuals and organizations to be represented. Please see Appendix A for a listing of Steering Committee members and individuals that participated in each Workgroup.

Figure 1.0 Prioritized Clinical Outcomes and Data Elements

PRIORITIZED HIE CLINICAL OUTCOMES
Better access to patient medical information across organizations (and providers)
Faster transmission and viewing results
Improved efficiency of care
Less caregiver repeating of historical information
Better access to medical information between providers/organizations
Avoid duplicate medical procedures, patient and caregiver access and use of personal medical record
Reduce duplicate medication use, fewer medical injuries
Decision support alerts and reminders
Medication reconciliation, reduce preventable hospitalizations
Assured completion of process, quality, safety and cost benchmarks
Improve emergency resource management

- Access and Continuity of Care Information
- Reduce redundant [illegible] and patient safety
- Support Quality [illegible]

NECESSARY DATA ELEMENTS	
#1	Demographics
#2	Medications and Diagnosis (equal rank)
#3	Allergies
#4	Laboratory
#5	Radiology
#6	Immunizations

12-16

CLINICAL

Chair: Howard Rodenberg, M.D., Health Director, Kansas Department of Health and Environment
Facilitator: Amy Helwig, M.D., Medical Director, eHealth Initiative

The Clinical Workgroup was charged with identifying and prioritizing clinical outcomes desired from HIE and the data elements necessary to achieve those outcomes. (Please see Figure 1.0). The clinical outcomes and data elements were then utilized to develop practical applications for information exchange, e.g. clinical messaging, e-prescribing, etc. (Please see Appendix B for Clinical Use Case Scenarios and Clinical Barriers.)

TECHNICAL

Chair: Diana Hilburn, M.S.M., Vice President and Chief Information Officer, Via Christi Health System
Facilitator: Jay McCutcheon, M.B.A., eHealth Initiative

The Technical Workgroup was tasked with measuring the HIT and HIE capacity in Kansas and addressing technical barriers related to interoperable HIE. This Workgroup conducted a technical assessment of HIT/HIE in Kansas (Please see Appendix C for Technical Assessment and Technical Barriers), assessed the Clinical Workgroup's practical applications (use case scenarios) to determine the technical feasibility of each, reviewed potential technical models for Kansas, and made recommendations.

FINANCE

Chair: Scott Glasrud, M.H.F.M, Chief Financial Officer, University of Kansas Hospital
Facilitator: Jay McCutcheon, M.B.A., eHealth Initiative

The Finance Workgroup was charged with evaluating existing HIE financial models and making recommendations for a sustainable financial model in Kansas. Based on reviews of existing HIEs as well as guidelines for state HIE efforts, a financial matrix was developed to assist new HIEs in developing a sustainable financial model. (Please see Appendix D for HIE Products and Services Matrix.)

GOVERNANCE

Chair: Robert St. Peter, M.D., President, Kansas Health Institute
Facilitator: John K. Evans, M.H.A., eHealth Initiative

The Governance Workgroup was chartered to examine governance needs, to coordinate and facilitate HIE implementation in Kansas, and explore potential public/private collaborative structures for an HIE organization that would support the development and implementation of HIE in Kansas. The Governance Workgroup identified the potential scope and role of a statewide HIE Coordinating Entity, as well as recommended guidelines for regional HIEs. (Please see Appendix E for Governance Workgroup Recommendations and HIE Guidelines and Appendix F for HIE Guiding Principles.)

PRIVACY AND SECURITY (HISPC)

Steering Committee Chair: Helen Connors, Ph.D., Executive Director, KU Center for Healthcare Informatics
Project Manager: Robert St. Peter, M.D., President, Kansas Health Institute
HISPC Workgroup Chairs:
Variations: Bill Bruning, J.D., President, Mid-America Coalition on Healthcare
Legal: Jeff Ellis, J.D., Partner, Lathrop and Gage
Solutions: Robert St. Peter, M.D., President, Kansas Health Institute
Implementation Plan: Judy Warren, Ph.D., Director of Nursing Informatics, KU Center for Healthcare Informatics

The Health Information Security and Privacy Collaborative (HISPC), under contract with RTI, assessed variations in business practices and policies relating to health information exchange, mapped those practices and policies to legal drivers, developed solutions to barriers to health information exchange, and developed an implementation plan for those solutions. The recommendations of the Kansas HISPC to enable health information exchange are included in this document.

12-17

Each Workgroup Chairperson also served as a member of the HIT/HIE Steering Committee to the H4C - chaired by former Lt. GovernorJohn Moore. The Kansas Health Policy Authority (KHPA) provided project management and staff support for the initiative.

04

12-18

Recommendations

The recommendations below are a synthesis of analysis, discussion, and deliberation by Kansas health care leaders and stakeholders over the last six months on how health information exchange can and should be developed in our state. These recommendations reflect their collective experience, expertise, and priorities. For information on the work products of each Workgroup, please see Appendices B-F.

A guiding principle of the Workgroups' efforts and of this report is to identify opportunities to advance HIE that are practical, achievable, and actionable. Scarce resources (financial, human, time, etc), lack of interoperability standards, and a dearth of proven HIE models demand careful examination of proposed actions. Therefore, the Workgroups emphasized a focus on incremental change. In addition to practical application, recommendations were considered from perspectives of urgency and feasibility. This report was constructed with initiatives that provide either a high level of urgent value, feasible value, or both.

Recommendation 1: Take Immediate Steps to Implement Short Term Recommendations of the Kansas HIT/HIE Policy Initiative

Recommendation 2: Create a Public/Private Coordinating Entity to Advance HIE over the Long Term

Recommendation 3: Provide Consumer and Stakeholder Education

Recommendation 4: Leverage Existing Resources

Recommendation 5: Demonstrate the Impact of HIE and Foster Incremental Change

Recommendation 6: Address Privacy and Security Barriers

Recommendation 7: Seek Funding from Multiple Sources

12-19

RECOMMENDATION 1
Take Immediate Steps to Implement Short Term Recommendations of the Kansas HIT/HIE Policy Initiative

The efforts of Workgroups through the Kansas HIT/HIE Policy Initiative over the past 180 days have resulted in a number of short-term and longer-term recommendations. While the longer-term recommendations are best undertaken by an established public/private entity, there are several immediate actions that should be taken to ensure that the momentum created by the Initiative continues and a statewide approach to HIE keeps pace with the developments occurring at the local and national level.

1.1 ESTABLISH A LEADERSHIP GROUP

It is recommended that a Leadership Group be immediately established to set the stage for developing a public/private structure. While it is expected that a separate governing body in the form of a public/private entity will be necessary to support the longer term recommendations of the Kansas HIT/HIE Policy Initiative, there is a need to maintain the momentum established over the past several months and begin advancing HIE.

To support continuity of purpose and ensure a smooth transition from recommendations to implementation, it is recommended that members of the current HIT/HIE Workgroups be considered for membership on the Leadership Group. The Leadership Group's role will include (Please see Appendix G for additional information):

- **Promote the Public Good through Leadership and Collaboration**
  Promote the public good by providing leadership and encouraging collaboration and cooperation among HIE initiatives in Kansas and across state lines. Support and facilitate the adoption of HIT. Ensure an equitable and ethical approach to the use of private and secure patient information for quality, cost, access, and public health reasons.

- **Provide Facilitation**
  Ensure a uniform approach to HIE in Kansas through the promotion of common technical guidelines. The technical guidelines and standards should be based on nationally recommended HIT and HIE standards. Address issues of redundancy or overlap between more than one HIE serving a similar geographic population. Identify intra and interstate interoperability issues. Leverage and consider opportunities to leverage existing infrastructure resources. Assist state agencies and collaborate with adjoining states, particularly Missouri, in promoting the use of health information for patients receiving care across state borders.

- **Provide Policy Recommendations to Policymakers and Key Decision Makers**
  Proactively identify needed policy changes to promote health information exchange and ensure the value of HIE is realized. Early efforts should address privacy and security issues and recommendations made by the Kansas HISPC project team.

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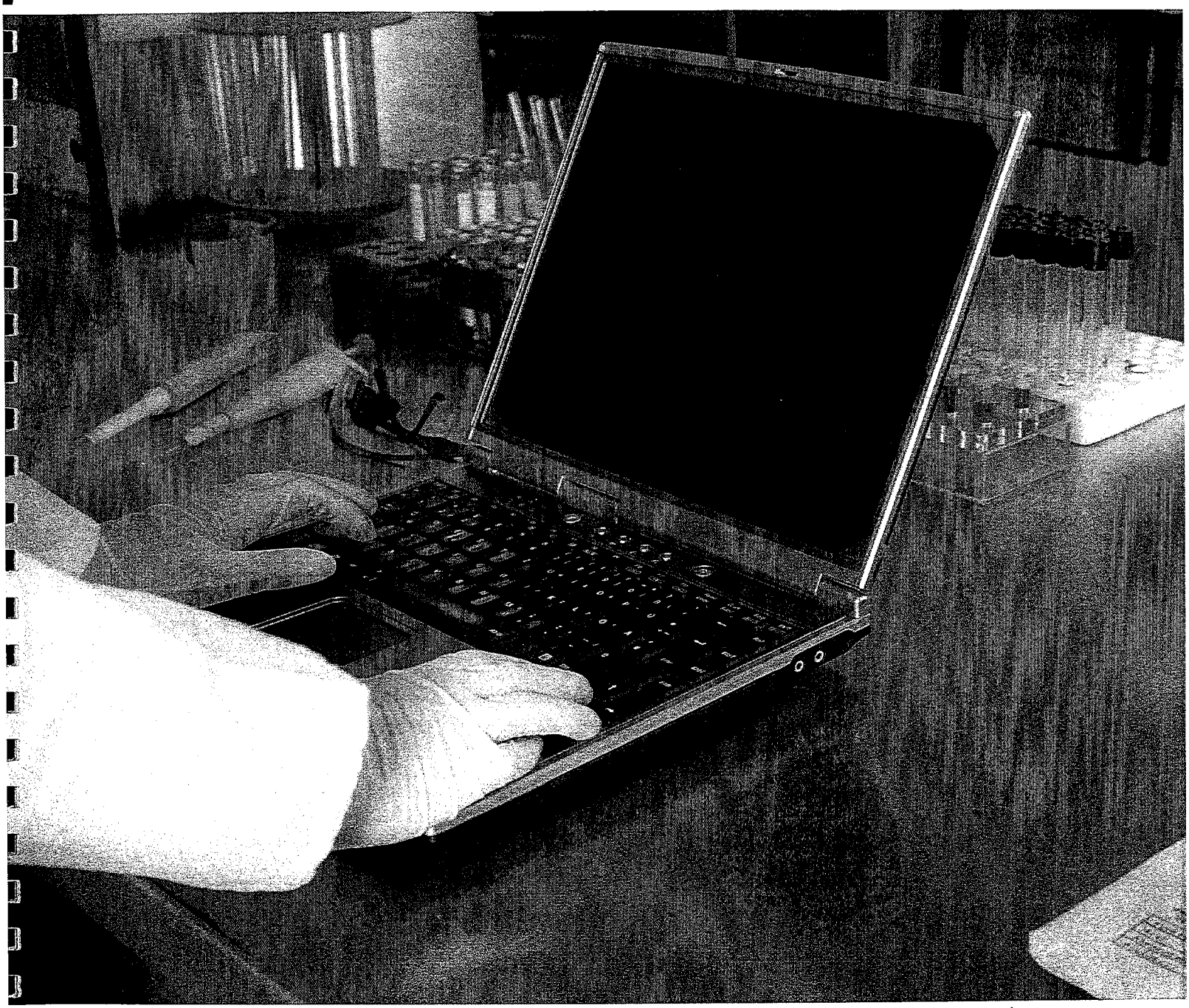

RECOMMENDATION 2
Create a Public/Private Coordinating Entity to Advance HIE over the Long Term

Create a statewide public/private Coordinating Entity that would assume the responsibilities and duties of the Leadership Group over the long term. The statewide entity should foster the adoption of HIT and interoperable HIE in a way that promotes the public good and supports regional HIEs in Kansas. It should also address the intra and inter-state interoperability issues identified by the Leadership Group. The Coordinating Entity should continue the initial work of the Leadership Group by serving as a resource and providing facilitation and policy recommendations to regional HIEs in the state, as well as encourage and enable collaboration and cooperation. This would include working with the State of Kansas to coordinate the HIT related actions and plans of all state agencies and programs.

THE LEGAL FORM AND THE DUTIES OF THE STATEWIDE COORDINATING ENTITY

- **Consider a Not-for-Profit Model**
  A 501 (c) (3) not-for-profit model should be considered as the most appropriate type of public/private entity to assume the aforementioned quasi-governmental role. This entity must also be anointed with sufficient authority to allow it to proactively promote HIT and HIE in the state of Kansas.

- **Coordinating Entity Membership**
  The recommended 501 (c) (3) entity would be governed by both governmental and non-governmental stakeholder representatives. The non-governmental Directors should dominate the Board and be nominated by stakeholders representing regional HIE initiatives across the state, as well as health care consumers. The governmental Directors would likely be designated by position or title.

- **Ensure a Standardized Approach to HIE**
  In addition to continuing the Leadership Group's initial work on developing common technical guidelines (based on national HIT and HIE standards), the Coordinating Entity should finalize and adopt the HIE Guiding Principles developed by the Governance Workgroup (see Appendix F) and negotiate standards for interoperability between regional HIEs. Additionally, the Coordinating Entity should seek to develop quantifiable metrics which measure the impact of HIE on the delivery system and promote public accountability by communicating these metrics, as well as establishing an acceptable level of accountability to the publics that HIE efforts serve. The coordinating entity shall also evelop the key components of a marketing and communications plan that emphasizes the public good of HIT and HIE.

- **Evaluate the Potential Role of HIE Certification**
  To ensure consistency and adherence to a core set of HIE expectations and guidelines the Coordinating Entity should consider the establishment of a certification process for HIE. The certification should establish a balance between promoting the development of HIE and not instituting burdensome requirements, while also seeking some level of commonality, consistency, and interoperability among Kansas HIE initiatives. This commonality, consistency, and interoperability could significantly improve effectiveness of HIE in Kansas.

- **Define regions for HIE**
  One effective way to define regions for HIE is to perform a Medical Trading Area (MTA) analysis. A Medical Trading Area is defined as an area where a population receives the majority of its health care. The area typically includes groups of physicians, hospitals, laboratories, mental health providers, and other health care providers that offer health care services.

12-22

This analysis can begin by generating simple charts, graphs, and maps. Those from discharge analysis and other tools should be used, such as the information for Kansas in the Dartmouth Atlas. Many of the areas will resemble the federal government's definition of metropolitan statistical areas but will expand beyond those areas where there is an established pattern of health care services provided to patients outside the metropolitan area or where there is a significant non-metropolitan grouping not yet defined as a metropolitan area.

Other systems or networks currently holding or exchanging information may also define regions and should be explored.

2.1 SERVE AS A RESOURCE CENTER FOR HIE IN KANSAS

Based on feedback from stakeholders and challenges experienced by other HIE efforts across the United States, a clear need exists to identify and provide specific resources to support and facilitate the adoption of HIT and promote HIE across the state. It is recommended that a Resource Center be established with full-time staff, as a single coordination point for Kansas HIE efforts. The Resource Center can be developed within or subcontracted by the statewide public/private Coordinating Entity and would perform the following scope of responsibilities:

- Work with the Public/Private Coordinating Entity to align public and private sector actions to innovate and transform health care through HIE
- Receive funds from public and private entities, apply for both governmental grants and non-governmental financial support to provide the following functions: development and planning of local HIE initiatives; establishment of baseline metrics to measure the impact of HIE on quality, safety, costs and satisfaction; and provide grants to implement local HIEs and potentially statewide infrastructure related efforts
- Work with the public/private Coordinating Entity to finalize HIE Guidelines (see Appendix E) and develop tools, including best practices to assist with forming a Regional Health Information Organization (RHIO), which is an organizational entity that administers and operates an HIE in a geographic area
- Provide or engage technical assistance and subject matter expertise for HIE efforts
- Assist with legal and regulatory issues
- Coordinate and track activities of HIE efforts at the local, regional and national level
- Provide a repository of lessons learned from HIE efforts across the state and the region
- Maintain momentum built during 2005 and 2006

12-23

A detailed overview of the Resource Center is provided in Appendix I.
See additional information on defining the regions, or Medical Trading Areas, as included in Appendix H, Kansas' Definitions of Regions

RECOMMENDATION 3
Provide Consumer and Stakeholder Education

The provider community, the health care industry, medical consumers, policy makers, and employers must be educated on HIT/HIE and the benefits of HIE. These efforts will be key to driving policy change, sustainable financing mechanisms, and gaining public acceptance of HIT/HIE systems. All parties participating in HIE development must communicate the need for end-user utility to system designers and administrators. Successful demonstration projects with well-documented outcomes will lead to greater measurable success for HIE projects throughout Kansas.

3.1 PATIENT/CONSUMER AND PROVIDER EDUCATION

Educate both providers and patients about HIT and HIE and their benefits. Emphasize "learning communities" that engage diverse stakeholders in "public listening" exercises rather than "public hearings." Foster broader participation by conducting these through workshops on the web or in person with open access for all. An ideal start is to begin with graduating health care professionals who are trained using HIT. Partnerships with Centers of Excellence in training health care professionals like the University of Kansas Center for Healthcare Informatics should be explored and leveraged for the benefit of the public.

Kansas has begun this process through a number of initiatives already underway. Employers, managers of community health records, private insurers, and the state Medicaid program have begun conversations with consumers to strengthen understanding, trust, and support of developing electronic health records projects.

3.2 USE COMMON HIT AND HIE TERMINOLOGY

Speaking a common language, both colloquially (HIE, HIT, et al) and technically (HL7, PHIN, etc.) is key to developing consensus on standards and a shared understanding of the capabilities and limitations of HIE. A priority for the next phase of HIE infrastructure development should be the development or use of a dictionary of standard terminology to be used throughout the effort. This should be incorporated into an education/communication plan. Where common terminology already exists through national or regional efforts, it should become the accepted standard.

3.3 BUILD UPON PHYSICIAN LEADERSHIP AROUND HIE ACROSS THE STATE OF KANSAS

Due to the rural nature of our state, a large portion of physician practices in Kansas are small practices. Utilization of health care remains, in large part, driven by physicians; and they will drive the system as a whole towards HIE and HIT and become active leaders in the effort when they see distinct benefits from it. Physician leadership can be promoted through the use of workshops and toolkits explaining HIE; research and practical models documenting a positive "return on investment" (improved quality of care and financials) encouraging physicians to champion the cause of HIE; and enlisting continuing close support from physician provider organizations such as the Kansas Medical Society, Kansas Association of Osteopathic Medicine, and the respective Kansas Chapters of the Academy of Family Physicians and Academy of Pediatricians.

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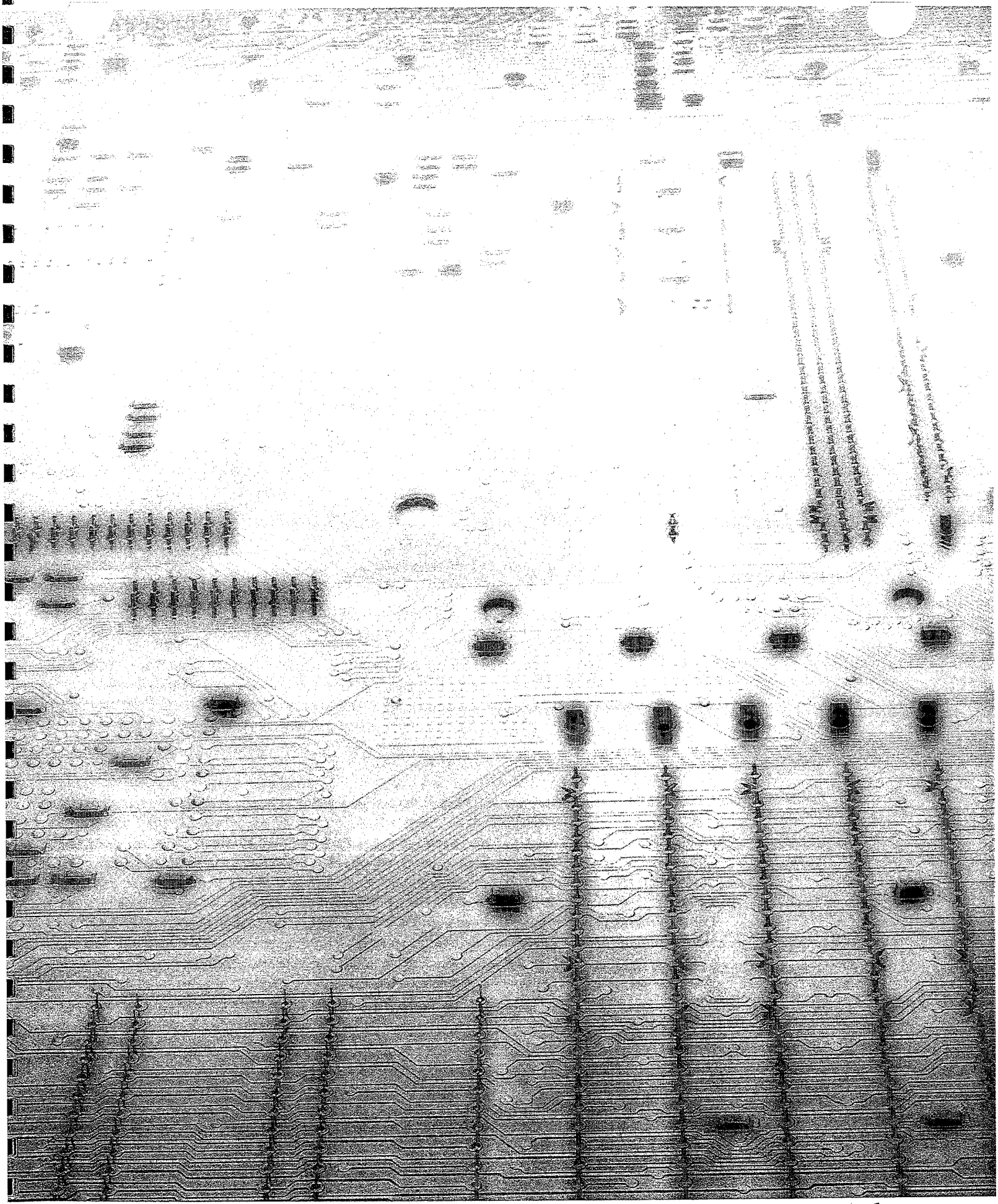


RECOMMENDATION 4
Leverage Existing Resources

In addition to the resources mentioned below, the technical assessment (see Appendix C for Technical Assessment) conducted by the Technical Workgroup can be utilized for future HIE planning and development.

4.1 LEVERAGE EXISTING INFRASTRUCTURE IN KANSAS

As a largely rural state, Kansas faces geographic challenges of access to health care and HIT. Collaboration by more than 80 Critical Access Hospitals and their community hospital partners throughout the state has resulted in a large number of relationships and common referral patterns that suggest an underlying order to patient flow and potential record exchange (Medical Trading Areas).

The Kan-Ed network allows hospitals to connect to a private, statewide network, but hospitals have been slow to join the network, and physician clinics and other health care providers are statutorily prohibited from connecting to Kan-Ed. Facilitating greater hospital participation and enabling additional health care providers, especially in rural areas, to connect to the Kan-Ed network would likely begin to close the current HIT gap and accelerate the implementation of HIE.

The creation and maintenance of networks and databases for public health, bioterrorism, and biosurveillance are significant activities. Where appropriate, increased coordination of investments by the State of Kansas in areas directly and tangentially related to HIT and HIE is necessary to streamline the system and minimize duplication.

4.2 LEVERAGE EXISTING HEALTH INFORMATION EXCHANGES IN KANSAS

Infrastructure development should look to existing HIE efforts for opportunities as well as consider the impact of further development. Current HIE projects in Kansas include the Kansas City employer-sponsored Healthe MidAmerica, Kansas City Regional Electronic Exchange (KCREE), KC Care Links, WebIZ (the statewide immunization registry developed by the Kansas Department of Health and Environment), Community Health Center Health Choice Project (developed by the Kansas Association for the Medically Underserved), and the Medicaid Community Health Record Pilot in Sedgwick County. In addition, with more than 60 sites across the state, the Kansas University Center for TeleMedicine and TeleHealth is dedicated to improving health across Kansas through HIT. These efforts could serve as building blocks for further exchange or other regional efforts, provide important lessons learned, and be a source of shared information that can benefit all HIE efforts, such as legal analysis of privacy and security issues.

12-26

4.3 USE EXISTING DATA SOURCES

The leadership provided by the State of Kansas can be an important motivator to ensure that these existing projects collaborate and address high priority functionality.

The State already holds several types of medical claims-based data, including the Kansas Health Insurance Information System (KHIIS), the Kansas Hospital Discharge Database, Medicaid, and State Employee Health Plan data. Diagnoses, procedures, medication histories, labs, and immunizations can be extracted from these existing databases, as with the Medicaid Community Health Record pilot, and serve as a model for an integrated HIE system. Noting that the State already holds this data can ease acquisition issues inherent in initial stages of HIE development. Complimentary resources such as claims data to support pilot opportunities will become available from private sector sources.

Additionally, existing public health databases such as Maternal and Child Health; Women, Infant, and Children's Nutritional Program; and Kansas Immunization Registry should be maximized without duplication of databases or infrastructure. Coordination of these existing data sources will improve the potential to achieve the Clinical Workgroup's recommendations for clinical outcomes from HIE while reducing the burden upon the originators of this data.

12-27

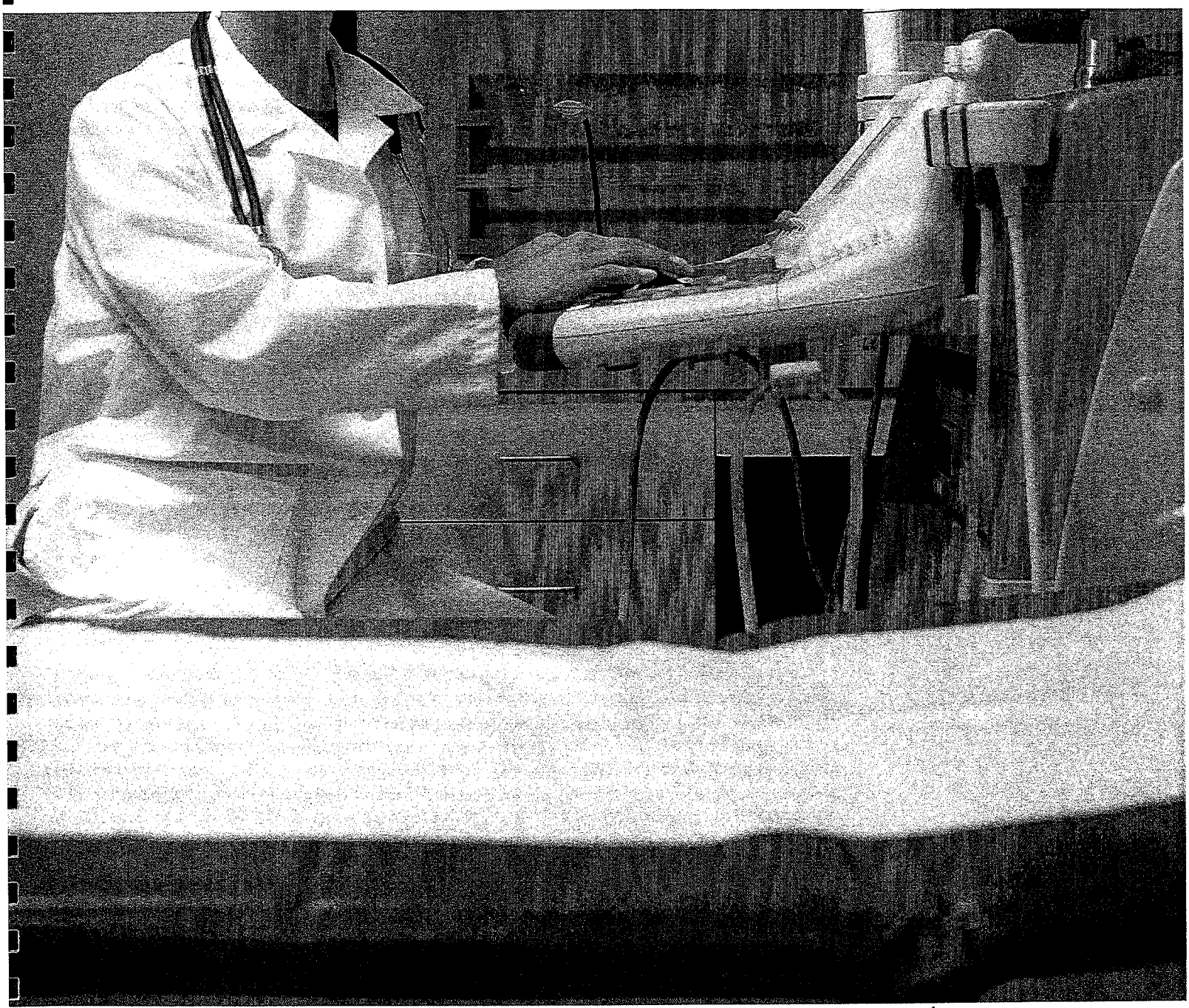
4.4 COORDINATE STATE AGENCY USE OF HIE

State agencies such as the Kansas Health Policy Authority, Kansas Department of Health and Environment, Kansas Department of Corrections, and others should coordinate on policy development, privacy and security issues, and infrastructure development for the exchange of health information to reduce duplication and ensure the highest levels of data integrity, privacy, and security.

The State of Kansas should leverage federal funding available to support HIT and HIE. Opportunities to leverage the marketplace and drive the adoption of HIT/HIE through state health care purchasing through Medicaid, the State Children's Health Insurance Program, and the State Employee Health Plan should be maximized. Coordination with CMS on statewide HIE initiatives should be considered as these programs have considerable overlap in efforts that address disease management and chronic care coordination, dual eligible patients, and early efforts on medical homes and home based clinical event monitoring.

4.5 LOOK TO CURRENT KANSAS MODELS FOR PRECEDENT REGARDING DATA SUBMISSION TO HEALTH CARE DATABASES AND THE SHARING OF HEALTH INFORMATION

Claims databases are often considered to be proprietary and may be excluded from an HIE effort unless required to do so. In Kansas, precedent exists for the legislative requirement of claims databases to submit information to the State (KHIIS) or for the voluntary submission of claims data to state agencies (the Kansas Database, held by KHPA).



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RECOMMENDATION 5
Demonstrate the Impact of HIE and Foster Incremental Change

5.1 DEMONSTRATE VALUE TO PROVIDERS THROUGH BOTH QUALITY AND FINANCIAL MEASURES

Providers will desire to use HIE systems, and demand that electronic systems be compatible with larger HIEs when improved quality of care, efficiency, and cost-effectiveness are demonstrated. The State can help demonstrate the value of HIT/HIE through the development and promotion of pilot projects like the Medicaid Community Health Record pilot in Sedgwick County or others that can demonstrate a positive impact on quality, safety, and workflow.

5.2 DEMONSTRATE VALUE TO PATIENTS AND CONSUMERS

In addition to the provision of education around HIT/HIE as mentioned above, information regarding pilot projects and other demonstrations should be made available to the public so that patients and consumers can know and understand the value of HIE and how it will benefit them. Efforts should be made to include patients and consumers in such demonstration projects.

5.3 DEMONSTRATE VALUE TO EMPLOYERS AND PAYERS

Employers are increasingly focusing on health care costs and the impact on their overall productivity and profitability. The Kansas City based Healthe Mid-America is an example of employers responding to health care costs proactively and using technology to coordinate care and drive efficiencies. Likewise the Medicaid Community Health Record pilot beginning in Sedgwick county is a response to the desire to deliver value through HIE. Large employers and payers can catalyze the adoption of HIT and need to be fully engaged in HIT/HIE discussions and understand the impact on health care quality, efficiency, and cost.

5.4 SUPPORT INCREMENTAL CHANGE

Successful models for HIE have been incremental. For example, a Cincinnati model started with fax servers delivering laboratory results to providers and over time evolved into a fully electronic exchange of laboratory orders and results. Implementation of HIE in Kansas should be incremental, building upon the technical capabilities of the majority of participants within a Medical Training Area and leveraging existing initiatives or resources. This type of approach will ease transition to a fully electronic exchange, minimize duplication and chance for error brought on by radical systems and process changes, be more cost-effective, and allow the value of HIE to be demonstrated, thereby facilitating the development of a financial model based on the entities which receive maximum benefit.

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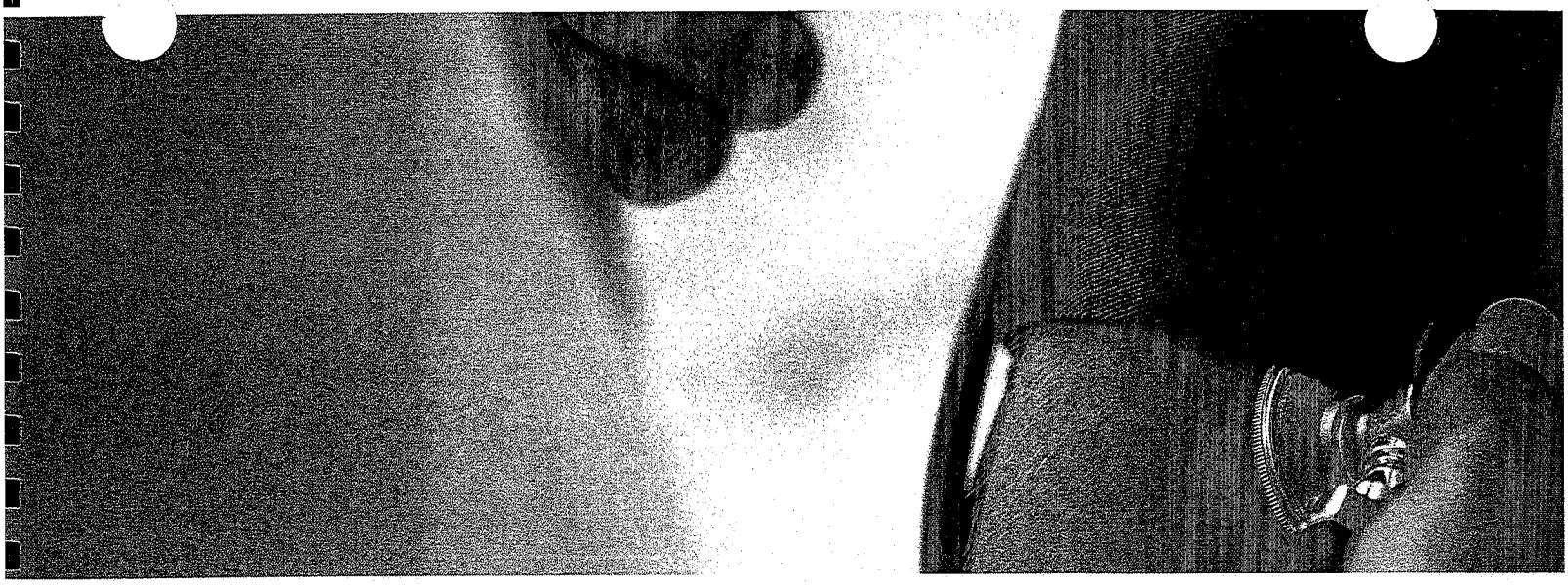


5.5 EVALUATE THE IMPACT OF HIE ON WORKFLOW AND MAKE THIS INFORMATION AVAILABLE TO CLINICIANS

Regional HIE systems throughout Kansas will not be used unless their use results in workflow efficiencies for clinicians. As HIEs are developed, the impact on workflow and business practice models and, ultimately, the financial impact of all potential end-users must be analyzed and measured. Special attention should be paid to the workflow impact on physician practices, especially small practices that are less able to absorb increased resource requirements. HIE systems that are not interoperable or require multiple systems and processes to access can actually end up costing physician practices. The level of resource requirement and the impact on quality and cost need to be carefully measured, shared with providers, and efforts must be made to maximize workflow efficiencies.

The American Academy of Family Physicians (AAFP) in Leawood, Kansas provides a local resource for enabling clinicians' use of HIT. Continued coordination with AAFP and other professional groups will provide Kansas clinicians an advantage in adopting and implementing HIT and HIE.

5.6 MEASURE THE FINANCIAL IMPACT OF HIE ON CLINICAL PRACTICE AND THE SUSTAINABILITY OF HIE THROUGH DEMONSTRATION PROJECTS

While the process of educating the health care community regarding HIE has been discussed, special focus should be placed on financial and quality of care measures in presenting HIE material to heath care providers. The impact of HIT/HIE implementation on cash flow and financial stability for a clinical practice, including opportunity costs, should be measured, and where possible, targeted incentives for providers should be considered to promote HIE.

12-31

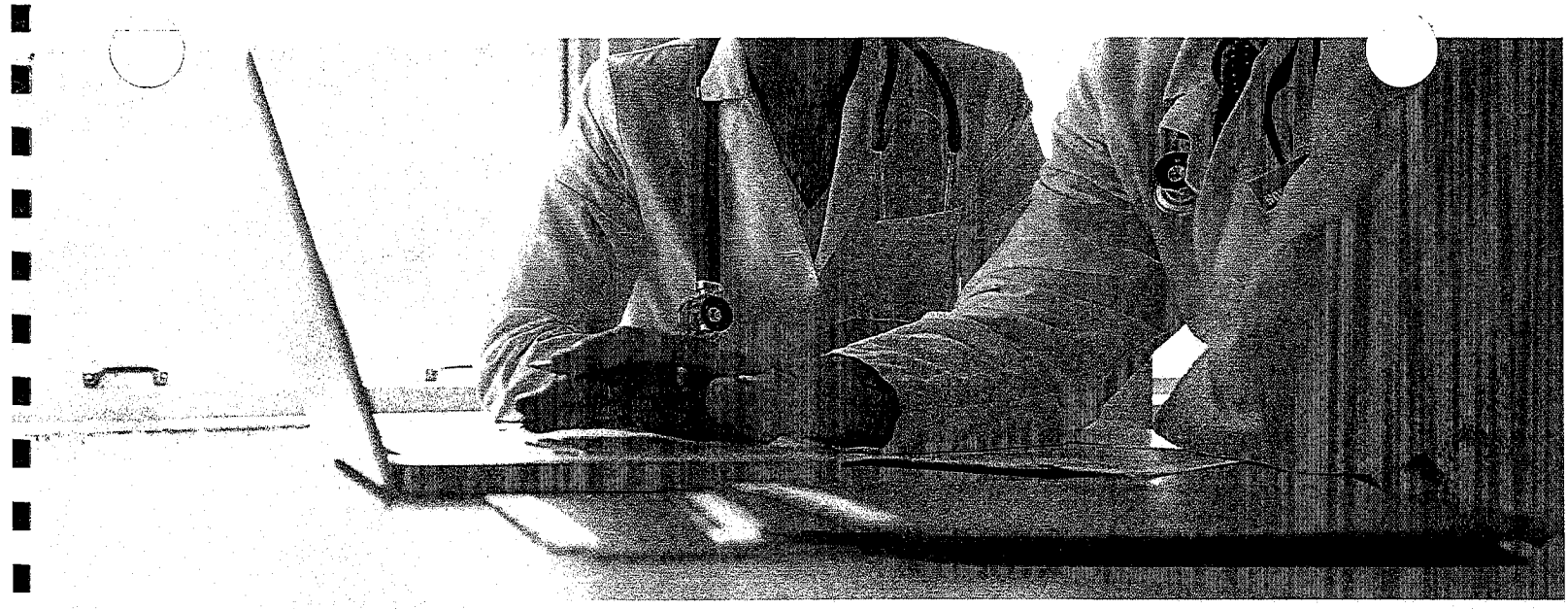
5.7 DETERMINE IF LEGISLATIVE OR REGULATORY CHANGES ARE NEEDED

Proprietary business models often feature deliberate "closeting" of data, isolating mutually exclusive data. Consequently, there may be a lack of incentives to companies to abandon this model in favor of a more open and interactive format. It should be determined if legislation enabling HIE is required.

Specifically regarding privacy and security, current laws and regulations should be reviewed to determine necessary technical corrections to reflect the technology available and enable HIE. This review has been initiated under the HISPC subcontract.

5.8 ENSURE THAT KANSAS' HIE SYSTEMS REMAIN "OPEN"

Regional HIE systems in Kansas should be designed to be "open" to facilitate integration with other unrelated systems. Stakeholders should aggressively promote interoperability standards and flexibility within these standards to reflect changes in technology and use. The State of Kansas and developing HIEs should utilize their leverage to encourage vendors in the state to adopt more open designs. The Coordinating Entity can encourage this openness by making it a condition for future support from the Resource Center and available funding. This condition may become a component of Certification outlined under Recommendation 2.



5.9 REQUIRE VENDOR CONTRACTS TO PROVIDE STANDARD UNIVERSAL INTERFACE SOFTWARE AND TO COMPLY WITH NATIONAL DATA STANDARDS

Once national technical standards are established, the standards must be disseminated to local providers and health care communities. Model contracts and work agreements describing these agreed-upon standards should be circulated to health care providers and purchasers for use in their own procurement of electronic health records or services. Busy providers are then freed from the costly and labor-intensive task of defining technical parameters for the purchase of individual EHRs and interfaces, and can drive market change by demanding interoperability.

5.10 TECHNICAL CONSIDERATIONS FOR REGIONAL HIES

The Technical Workgroup identified several technical issues that regional HIEs will need to consider when developing an exchange. It is essential to contemplate these issues when building a technical framework for HIE.

- Begin to establish the mechanism to create a master patient/person index and the matching criteria.
- Create and maintain a patient directory with opt-in/opt-out selection.
- Create and maintain a central directory of providers.
- Ensure adequate IT support is available to health care providers utilizing HIT/HIE.

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RECOMMENDATION 6
Address Privacy and Security Barriers

The Health Information Security and Privacy Collaborative (HISPC), as mentioned earlier, assessed variations in business practices and policies relating to health information exchange and developed solutions to barriers to HIE. Their recommendations centered on the protection of individuals' private health information while enabling interoperable health information exchange, and focused on nine specific domains. The HISPC Workgroups' recommendations are listed below.

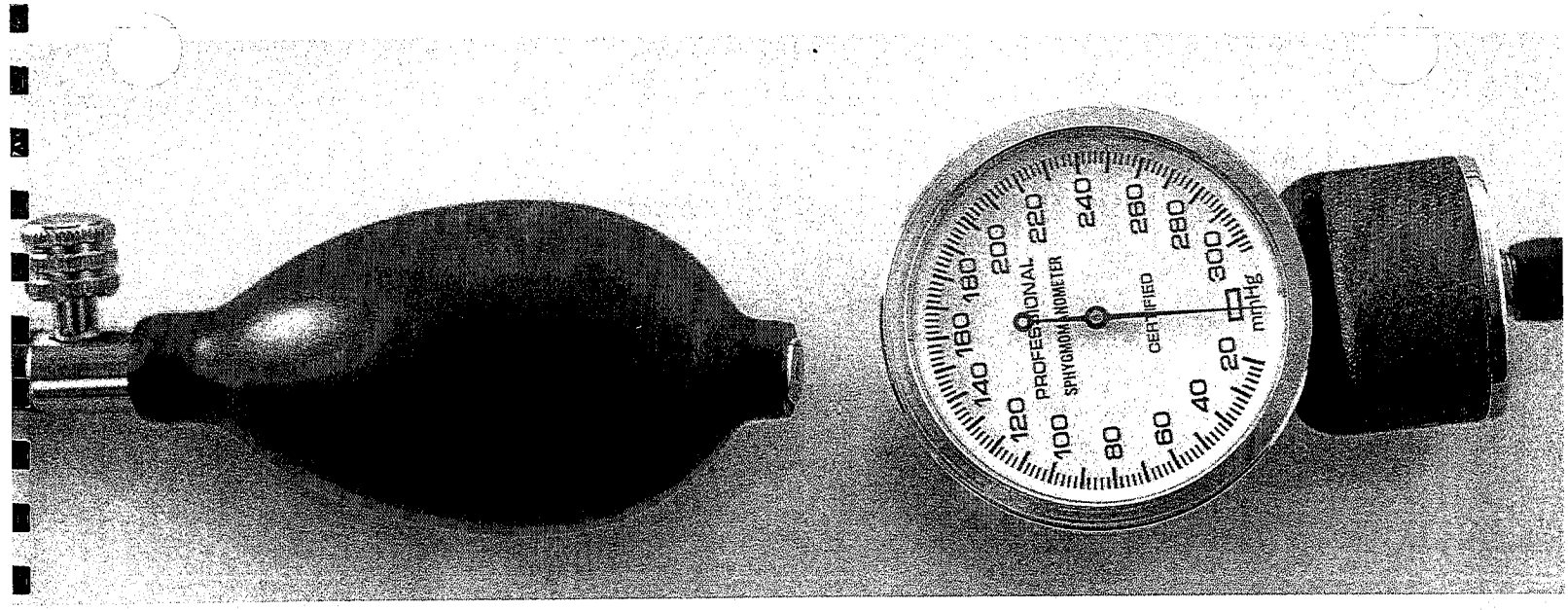
PATIENT-FOCUSED SOLUTIONS

- Patient education--i.e. information about one's rights; preparation for granting of informed consent; and, acquisition of technical skills to navigate and interpret stored information;
- Patient identification, access to one's own information, and the ability to edit some portion thereof;
- Patient control over permitted conditions for data disclosure: how much information, to whom, for what purpose, for how long - i.e., patients' control over the rules;
- Patient notification, accounting, and audit of prospective and retrospective data uses and disclosures;
- Patient consent, denial or revocation of consent for specific instances of information use and disclosure - i.e., patients' responses to specific authorization requests– as well as those of medical power of attorney and other personal representatives.

The state faces several vexing concerns. How does providers' gradual conversion from paper to electronic record-keeping systems change the meaning of privacy and security requirements and expectations? Will standards be set by the market, by regulation, or by both? How can private citizens participate in setting the ground-rules for such solutions, particularly those that are market-based?

BUSINESS OPERATIONS-FOCUSED SOLUTION STRATEGIES

- Require a multi-level (at least 2 factor) process for authentication of users of protected health information (PHI).
- Establish varying levels of access to PHI based on user roles.
- Institute best practices among techniques for assigning patient and provider IDs.
- Educate stakeholders on baseline expectations for network level security.
- Establish complete, auditable, and reversible revision histories for electronic health records.
- Conduct periodic external audits of information access logs as well as tests of system "hardness" against attempted breaches.
- Establish administrative and physical security safeguards that meet or exceed the HIPAA security standard. Enforce encryption of PHI.



LEGALLY-FOCUSED SOLUTION STRATEGIES

Most state privacy laws and regulations predate HIPAA and simply do not contemplate widespread electronic data storage and interchange. The Legal Working Group of the Kansas HISPC felt that state privacy laws and regulations should be reviewed and amended to comply with HIPAA as the minimum standard for privacy restrictions. (HIPAA does not preempt state laws whose provisions are more stringent than the federal law.) Two possible approaches were discussed: (1) a comprehensive review of information privacy provisions in Kansas statutes and administrative regulations, which would be a considerable undertaking, but might produce the highest resulting level of consistency; or (2) a more incremental approach, dealing only with those areas of the law necessary to enable specific health information exchange applications as they arise, which might be more palatable or feasible.

Ultimately, the Legal Working Group recommended that the LWG, or some similar group, be tasked to undertake (1) the development of a consistent and comprehensive statewide interpretation of HIPAA and its interplay with state laws and regulations; (2) the identification of state laws and regulations needing revision to bring them into compliance with HIPAA for the purpose of facilitating electronic HIE; (3) lobbying for the creation of safe harbors from federal enforcement of HIPAA violations which would help remove the fear of electronic HIE for providers; and (4) promoting education of providers and consumers about the proper use of HIE. These actions might mitigate the barrier that could arise from citizen uncertainty about rules of HIE and provider uncertainty about the enforcement of HIPAA violations, thereby creating an atmosphere that would promote the potential of electronic HIE.

REGIONALLY-FOCUSED SOLUTION STRATEGIES

Medical trading areas, including both inter- and intra-state, must be taken into account when developing HIEs. Additionally, the challenges associated with exchanging patient health information across state lines must be addressed. Kansas is geographically diverse and one of the most rural states in the country. Kansans who live in frontier counties commonly travel to other states to obtain health care services from the closest concentrations of providers. Similarly, Kansans living in the Kansas City metropolitan area may go to Missouri for services. Just as common, however, is the treatment in Kansas City or Wichita - a regional center possessing numerous specialty hospitals - of residents from other states.

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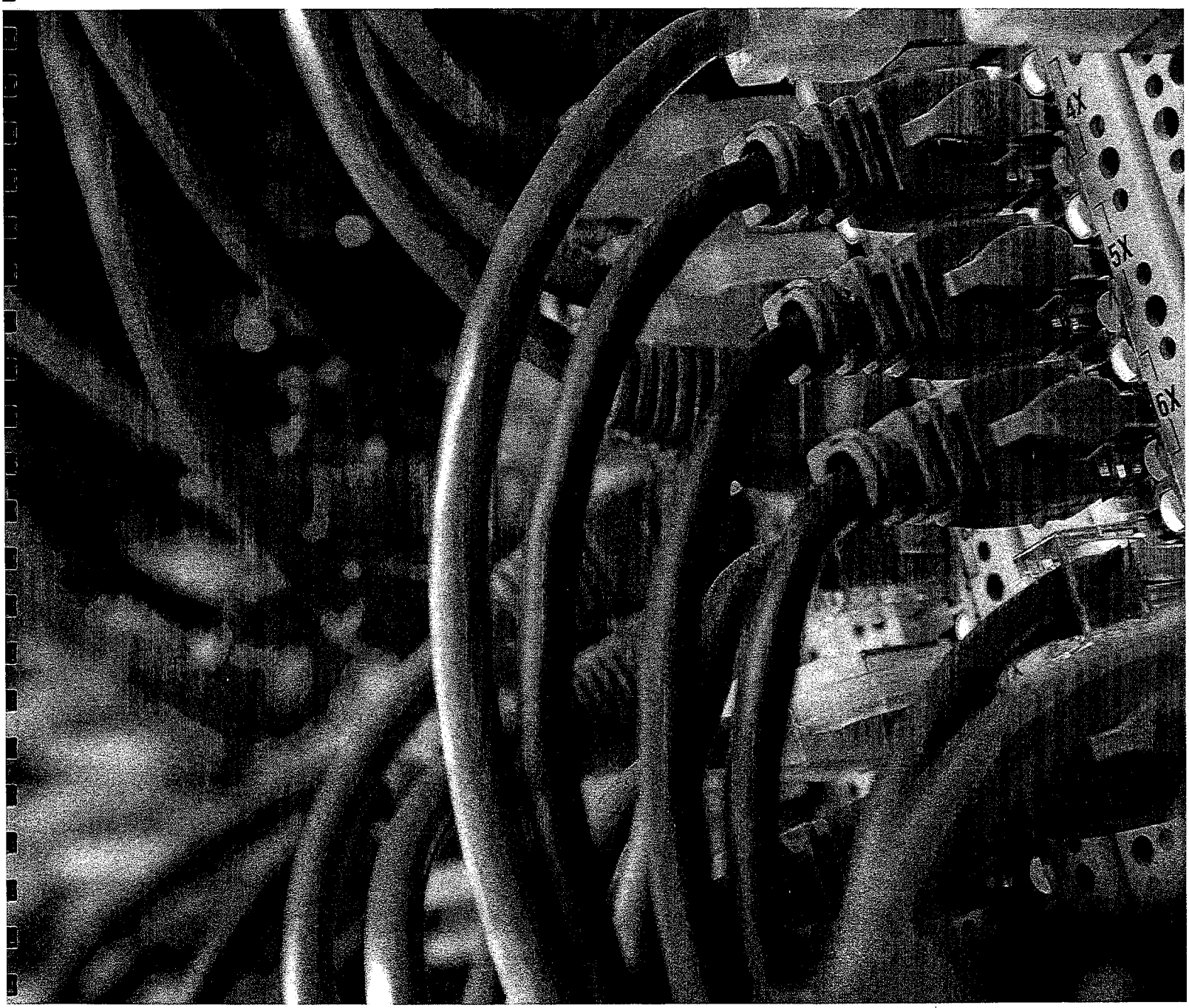
RECOMMENDATION 7
Seek Funding from Multiple Sources

FUNDING OPPORTUNITIES

Once a financial model has been proposed, developing HIEs should seek seed funding from a variety of sources. With many small, private physician practices in Kansas, regional HIEs will need alternative funding to supplement start-up and potentially operational costs. The public/private Coordinating Entity and/or Resource Center can assist with the identification of available funding and/or the provision of grant funds to catalyze HIE. Consideration should be given to the development of an investment fund that can be used to fund innovations in HIE.

Additionally, Federal agencies such as the Department of Health and Human Services, Agency for Healthcare Research and Quality, and Federal Communications Commission have made funds available for different stages of HIE implementation. National organizations like the American Heart Association have expressed an interest in collaborating with initiatives to seek alternative funding sources.



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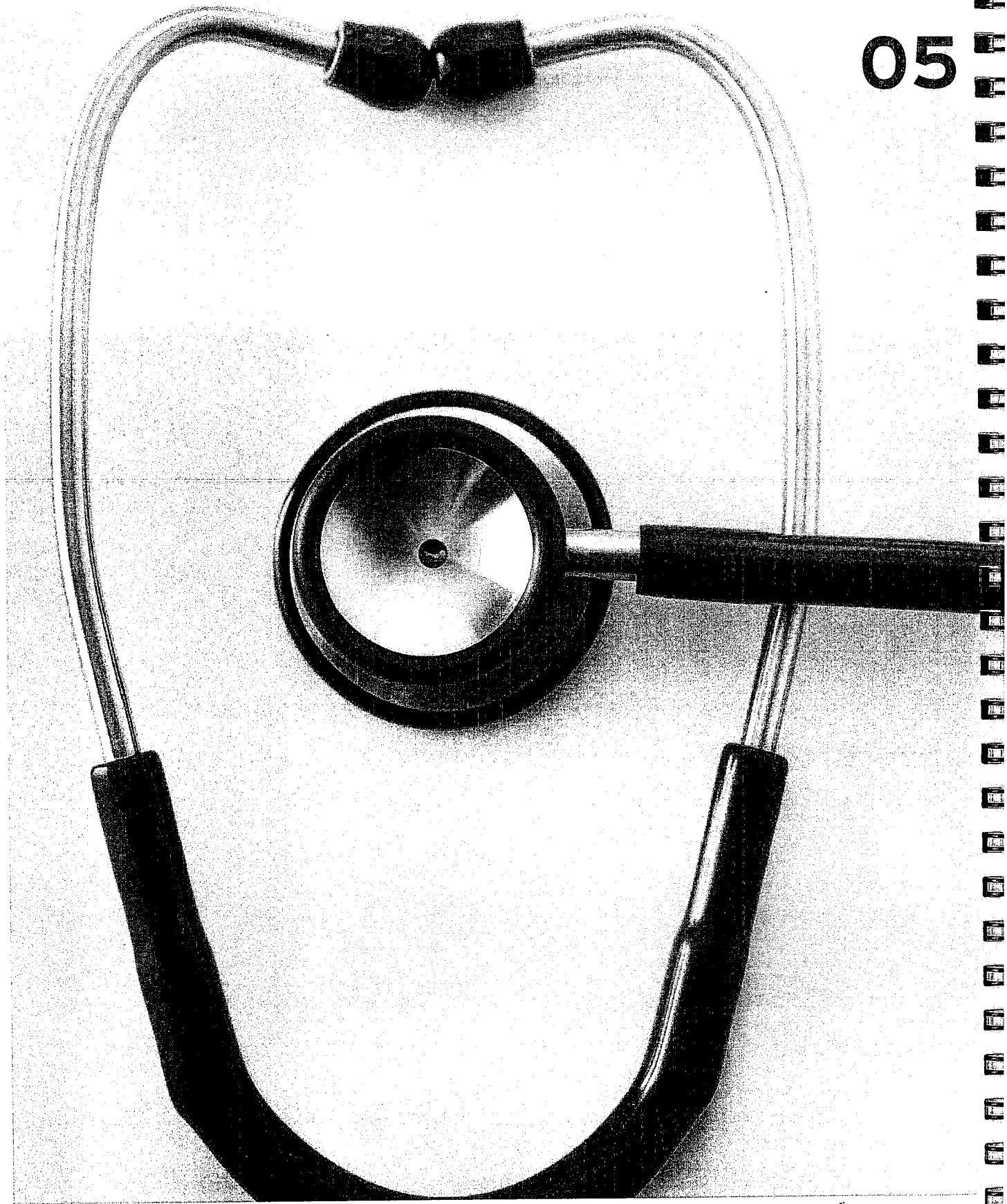

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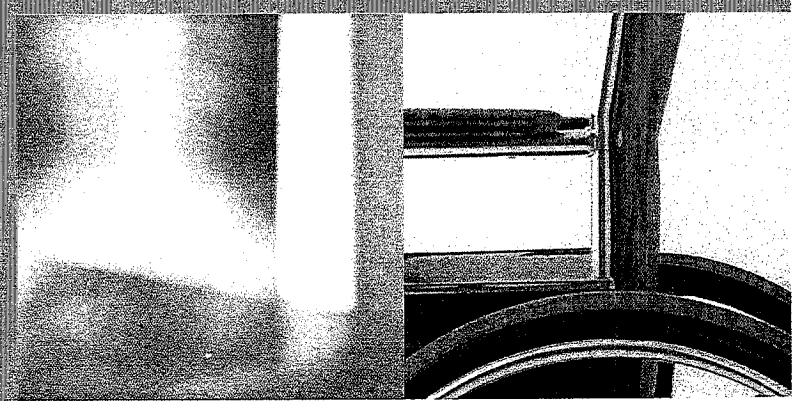
Conclusion

Health information technology and health information exchange have great potential to transform our health care system. However, momentum must be maintained, stakeholders must be educated, existing resources should be leveraged, the impact needs to be demonstrated, funding must be secured, and systems must be created to ensure personal health information is kept private and secure and patients control their own health information. Kansas has a number of public and private HIE initiatives ongoing in the state, as well as a great deal of interest and commitment amongst providers, consumers, and payers, which positions Kansas well to improve health care through health information technology.

Recognizing the value of HIT/HIE and the efforts of the HIT/HIE Policy Initiative, Governor Sebelius completed Recommendation 1, Establish a Leadership Group, by appointing the Health Information Exchange Commission on February 7, 2007. The HIE Commission will work as a public/private collaboration to bring providers and stakeholders together to advance the use of information technology in health care and to advance the recommendations of the Workgroups created through the HIT/HIE Policy Initiative. The HIE Commission should coordinate and focus the state's continuing efforts to improve health care quality and cost effectiveness through HIE.



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06 Appendices

Appendices B-I are available online at www.khpa.gov
Appendix A: Steering Committee and Workgroup Membership
Appendix B: Clinical Use Case Scenarios and Clinical Barriers
Appendix C: Technical Assessment and Technical Barriers
Appendix D: HIE Products and Services Matrix
Appendix E: Governance Workgroup Recommendations and HIE Guidelines
Appendix F: HIE Guiding Principles
Appendix G: Establish Leadership Group
Appendix H: Kansas' Definition of Regions
Appendix I: Establish a Resource Center

APPENDIX A
Steering Committee and Workgroup Membership

STEERING COMMITTEE
Chair: John Moore, former Lt. Governor, State of Kansas
Tom Bell, Kansas Hospital Association
Rod Bremby, Kansas Department of Health and Environment
Helen Connors, KU Center for Healthcare Informatics
Joe Davison, West Wichita Family Physicians
Scott Glasrud, University of Kansas Hospital
Diana Hilburn, Via Christi Health System
Jan Nicholson, Spirit AeroSystems, Inc.
Marci Nielsen, Kansas Health Policy Authority
Howard Rodenberg, Kansas Department of Health and Environment
Robert St. Peter, Kansas Health Institute
Bill Wallace, Blue Cross Blue Shield of Kansas, Inc.

CLINICAL WORKGROUP

Chair: Howard Rodenberg, Kansas Department of Health and Environment
Facilitator: Amy Helwig, eHealth Initiative and Foundation
Staff: Gretchen Speer, Kansas Health Policy Authority
Members:

- Judy Bagby, Medicalodges, Inc.
- Jennifer Brull, Prairie Star Family Practice
- Dennis Cooley, Pediatric Associates
- Godfrey Duru, LabCorp
- Joe Davison, West Wichita Family Physicians
- Janis Goedeke, Crawford County Health Department
- Travis Haas, Kansas Association for the Medically Underserved
- Brad Marples, Cotton-O'Neil Clinic/Stormont-Vail HealthCare
- R.W. Meador, Barber County Hospital
- Ken Mishler, Kansas Foundation for Medical Care, Inc.
- Charles Porter, University of Kansas Hospital
- Kristi Schmitt, Finney County Health Department
- Pam Shaw, University of Kansas Medical Center
- Jeanna Short, Susan B. Allen Memorial Hospital
- Jill Sumfest, Preferred Health Systems
- Chris Tilden, Kansas Department of Health and Environment
- Craig Yorke, Kansas Health Policy Authority

TECHNICAL WORKGROUP

Chair: Diana Hilburn, Via Christi Health System
Facilitator: Jay McCutcheon, eHealth Initiative and Foundation
Staff: Gretchen Speer, Kansas Health Policy Authority
Members:

- Ken Abendshien, Midwest Health Systems Data Center
- Bryan Dreiling, State of Kansas
- Dan Elliott, Flint Hills Community Health Center
- Jennifer Findley, Kansas Hospital Association
- Brian Huesers, Kansas Department of Health and Environment
- Jerry Huff, Kan-ed
- Ron Liebman, Kansas Health Institute
- Deborah McDaniel, Kansas Health Information Management Association
- Brenda Olson, Great Plains Health Alliance
- Charles Porter, University of Kansas Hospital
- Scott Rohleder, Hays Medical Center
- Gregory Smith, Kansas State University
- Scott Vondemkamp, Blue Cross Blue Shield of Kansas, Inc.
- Steven Waldren, American Academy of Family Physicians Center for Health IT
- Neil Woerman, Kansas Insurance Department

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FINANCE WORKGROUP

Chair: Scott Glasrud, University of Kansas Hospital
Facilitator: Jay McCutcheon, eHealth Initiative
Staff: Chase H. Finnell, Kansas Health Policy Authority
Members:
- Todd Kasitz, Preferred Health Systems, Inc.
- Kathy Fors, Kansas City Independent Physicians Association
- Carolyn Gaughan, Kansas Academy of Family Physicians
- Margo McDonald, AMS Reference Lab
- Rose Mulvany-Henry, Boult, Cummings, Conners & Berry PLC
- Liz Ramsey, Manhattan Radiology LLP
- Chris Swartz, Kansas Health Policy Authority

GOVERNANCE WORKGROUP

Chair: Robert St. Peter, Kansas Health Institute
Facilitator: John K. Evans, eHealth Initiative
Staff: Chase H. Finnell, Kansas Health Policy Authority
Members: Doug Anning, Polsinelli Shalton Welte Suelthaus, PC
- Rod Bremby, Kansas Department of Health and Environment
- Bill Bruning, Mid-America Coalition on Health Care
- Collier Case, Sprint
- Jeff Ellis, Lathrop and Gage, LC
- Jim Hansen, Healthe Mid-America
- Michele Meier, Kansas Medical Clinic
- Billie Hall, Sunflower Foundation
- Melissa Hungerford, Kansas Hospital Association
- Jackie John, Great Plains Health Alliance
- Tom Lenz, Centers for Medicare and Medicaid
- Marci Nielsen, Kansas Health Policy Authority
- Larry Pitman, Kansas Foundation for Medical Care, Inc.
- Vicki, Schmidt, Kansas Senate
- Kevin Sparks, Blue Cross Blue Shield Kansas City
- Gary Caruthers, Kansas Medical Society
- Peter Stern, Kansas Independent Pharmacy Services Corporation
- John Wade, Kansas City Regional Electronic Exchange
- Bill Wallace, Blue Cross Blue Shield Kansas, Inc.
- Bruce Witt, Preferred Health Systems, Inc.

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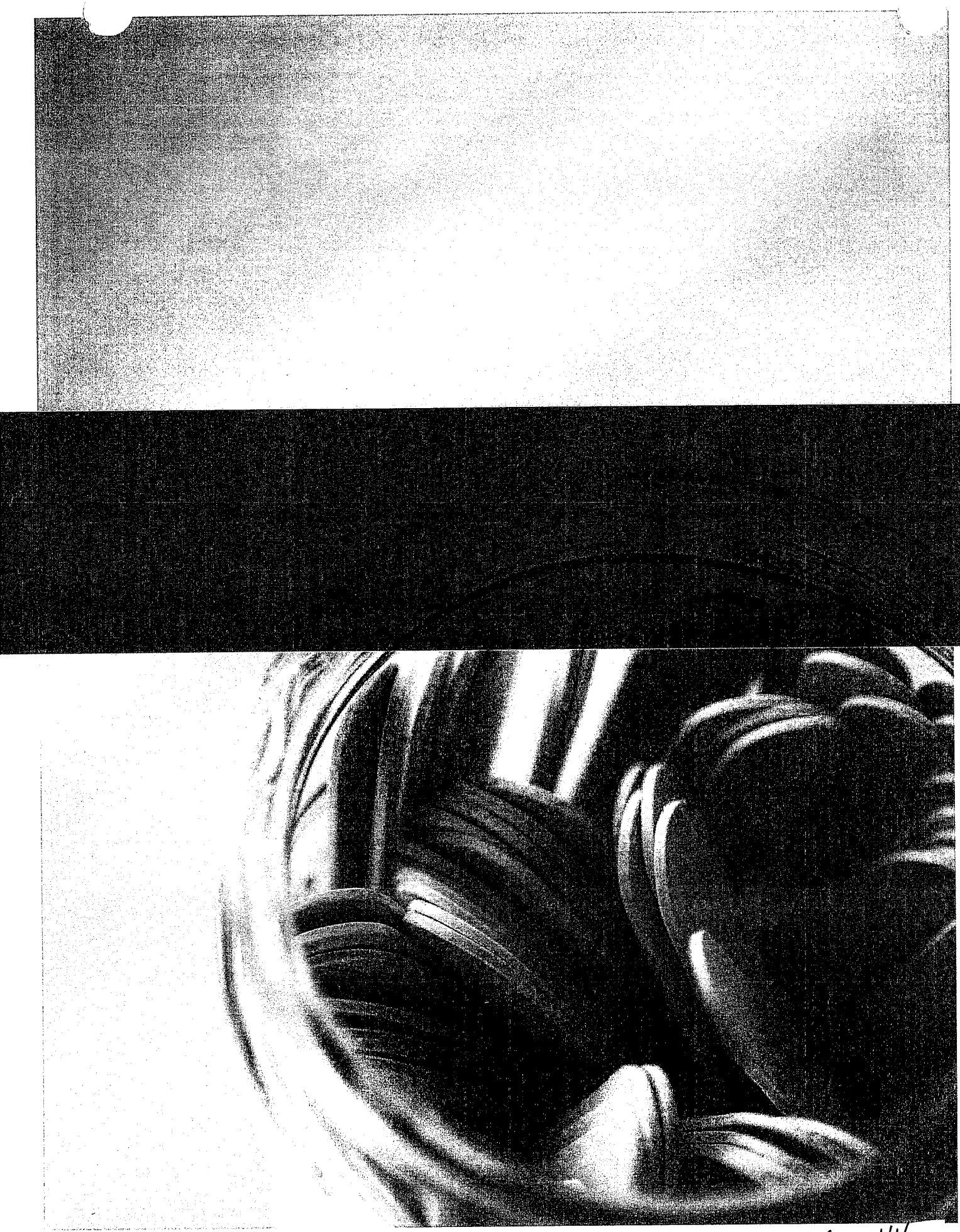

KANSAS

DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

Don Jordan, Secretary

Joint Committee on Health Policy Oversight
June 12, 2009

ARRA Funds for Health Information Technology Development

For Additional Information Contact:
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Patrick Woods, Director of Governme
Docking State Office Building, 6th Fl
(785) 296-3271

Joint Committee on Health Policy Oversight
6/12/09
Attachment 13

KANSAS
DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

ARRA Funds for Health Information Technology Development

Joint Committee on Health Policy Oversight

Chairman Barnett and members of the committee, thank you for the opportunity to provide information about health information technology (HIT) and efforts to promote HIT in Kansas. I am Don Jordan, Secretary of the Department of Social and Rehabilitation Services and Chairman of the Health and Human Services (HHS) Subcabinet.

The federal government has made funding available as part of the American Recovery and Reinvestment Act (ARRA) to support Health Information Technology (HIT) development. In this context HIT involves the development and sharing of electronic medical records and other health information with the goals of improving health outcomes and making the healthcare system more efficient. Currently, medical information is recorded in a variety of ways, in many places still on paper records. Recording health information digitally will establish the potential for healthcare providers to share the information more quickly and accurately. Records are now created and/or saved electronically in a variety of formats and standards, many of which are proprietary, hindering the sharing of information. Developing and standardizing these electronic health records is an important part of advancing HIT.

Governor Parkinson has assigned the HHS Subcabinet with overseeing the tasks of indentifying appropriate HIT projects for ARRA funding, assuring applications are completed and submitted in a timely fashion and managing the process in an effective and efficient manner. The HHS Subcabinet includes the Juvenile Justice Authority and the Departments of Aging, Corrections, Health and Environment and SRS. The Kansas Health Policy Authority and DISC also participate in the subcabinet's activities. KDHE is taking the lead for the subcabinet for this project. In addition, it will be important that we involve the E-Health Advisory Committee and other stakeholders to make sure we make wise investments for Kansas.

This will be a complex process, but one that offers real opportunity for Kansas to take some major strides forward.

I will now stand for questions.

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