Chapter 16: Quality Improvement in KHPA's Health Care Programs

Executive Summary

Description

The primary goal of quality improvement at KHPA is to use the resources the agency manages to purchase and promote high quality health care for the populations we serve. In operational terms, quality health care can be described as successfully obtaining the health care services needed, at the time they are needed, to achieve the best possible results. Quality health care may also be defined as appropriate utilization of health care services by avoiding underuse, overuse, and eliminating misuse. KHPA quality improvement efforts are intended to systematically and deliberately assess, measure and analyze quality within and across its programs. Quality monitoring is a process of ongoing regular collection and analysis of a core set of health indicators. For KHPA programs, these indicators are focused on optimal health outcomes and efficiencies.

KHPA will use the following strategies to identify and address opportunities for improving the quality of care provided in our health care programs:

1. Regular and systematic assessment and monitoring of available quality data in the form of:
    a. Routinely collected and standardized data drawn from surveys and administrative health data.
    b. Targeted analyses and special data collections.
2. Identifying measures across KHPA programs to compare quality and enhance coordination of health care purchasing.
3. Working with program managers and agency leadership to review program quality data and make that data available to the public.
4. Recommending quality-enhancing policies to program managers and agency leadership.

Key Points

- *Limited Quality Evaluation Within Programs*
  Health care quality evaluation for KHPA's programs has historically focused on HealthWave, the Medicaid managed care program that provides health care services to low income Kansas children and pregnant women. The quality improvement activities in HealthWave have consisted primarily of those required by the Center for Medicare and Medicaid Services (CMS). However, neither the quality of services provided under the traditional FFS Medicaid program, HealthConnect, or the State Employee Health Benefits Plan (SEHBP) have been systematically evaluated.

- *Limited Comparability of Quality Improvement Across Programs*

KHPA has engaged in a number of quality improvement efforts in HealthConnect, Medicaid FFS, SEHP, and the state worker's compensation plan. However, different measures have been used to assess each of the KHPA programs and therefore results are not comparable across programs.

Kansas Health Policy Authority (KHPA) Staff Recommendation

- Share baseline quality health care data publicly. The first step in a quality improvement process is to establish baseline levels of program performance, and to share these results widely. Sharing quality data facilitates understanding, motivates change and informs consumers. This review of the quality program will serve as a baseline for continuous improvement, outline the quality activities currently underway across KHPA programs and highlight gaps and opportunities for improvement. The Kansas Health Policy Authority will publish quality and outcomes data that are currently collected for the HealthWave and HealthConnect programs. This complements the work of the KHPA Data Consortium, an advisory group to the KHPA Board, which is tasked with developing recommended quality indicators and health measures for the state as a whole.

- Obtain funding for new data collection. Data will be collected from beneficiaries and providers participating in our fee-for-service programs in order to evaluate performance, identify opportunities for improvement and facilitate comparability across programs. The data will be analyzed by KHPA's external quality review organization (EQRO). KHPA is currently re-bidding its EQRO contract for Medicaid and HealthWave. Although additional data from beneficiaries and providers is needed, our goal is to minimize any administrative burden for those who participate in Kansas Medicaid.

- Promote the use of health information technology in the Kansas Medicaid and State Employee Health Plan programs by implementing a Community Health Record for all program participants statewide. Two health information technology pilots are currently being tested and preliminary reviews suggest promising results. KHPA promotes the use of health information technology to better coordinate care, especially in the context of a medical home, improve health outcomes and ultimately help to reduce health care costs.

Program Overview

In 2006 the Kansas Health Policy Authority (KHPA) was established with the duty to "develop and maintain a coordinated health policy agenda that combines effective purchasing and administration of health care … to be exercised to improve the health of the people of Kansas by increasing the quality, efficiency and effectiveness of health services and public health programs (K.S.A. 75-7401 et seq.)." Under this authority, KHPA is responsible for all of the state's publicly funded health insurance programs, including Medicaid, State Children's Health Insurance Program (SCHIP) and MediKan (Table A). The state is also responsible for health care coverage for state employees through the State Employee Health Benefits Plan (SEHBP) which has two components. One component is health care coverage for state employees, eligible retirees and non-state groups – the State Employee Health Plan (SEHP). The second component manages the State Self-Insurance Fund (SSIF) that administers worker's compensation benefits for state employees. Table A displays the specific programs for which KHPA has purchasing and payment responsibilities. Oversight of the agency lies with an independent board of health care experts, practitioners and cabinet officers.

Table A
Public Insurance Programs and Populations Served

	TitleXXI Children[1]	TitleXIX Pregnant Women, Children* and Adult Caretaker Medical	Title XIX SSI, MediKan[3] Disabled	Title XIX Elderly and Other*	Responsible State Agency
Physical Health Programs	HealthWave	HealthWave HealthConnect PCCM[2]	HealthConnect PCCM	FFS	KHPA[4]
Behavioral Health Programs	HealthWave	PAHP[5]	PAHP	PAHP	KHPA SRS[6]
Substance Abuse	HealthWave	PIHP[7]	PIHP – Disabled only	PIHP	KHPA SRS

[1]Children: Persons from birth up to 19 years of age.
[2]HealthConnect option available only in Region 3.
[3]MediKan: Physical health program through state funds only.
[4]KHPA: Kansas Health Policy Authority.
[5]PAHP: Prepaid Ambulatory Health Plan for mental health benefits.
[6]SRS: Social Rehabilitation Services.
[7]PIHP: Prepaid Inpatient Health Plan for mental health benefits.
*Managed care opt-out populations are identified in 42 CFR 438 as SSI Children under 21 years of age, Children with Special Health Care Needs and/or Native Americans.

KHPA purchases health care for nearly half-million Kansans each year, with total expenditures of nearing $2 billion annually. To provide direction in policy making and program administration the Board established vision principles (Appendix A). These six principles include three that are focused on quality in health care:

- *Access to Care*. Every Kansan should have access to patient-centered health care and public health services ensuring the right care, at the right place, and the right price. Health promotion and disease prevention should be integrated directly into these services.
- *Quality and Efficiency in Health Care.* The delivery of care in Kansas should emphasize positive outcomes, safety and efficiency and be based on best practices and evidence-based medicine.
- *Stewardship*. The Kansas Health Policy will administer the resources entrusted to us by the citizens and the State of Kansas with the highest level of integrity, responsibility and transparency.

Quality Improvement Program

The quality improvement program provides KHPA, our partners, policymakers and stakeholders with information about health outcomes, resource use and program effectiveness. The rationale for sharing quality data is to better inform decision making by beneficiaries, program staff, KHPA and other policymakers.

A number of quality improvement initiatives are currently conducted by KHPA, building on the work of several long-standing advisory groups and committees that have historically served Kansas Medicaid. In 2008, an internal quality workgroup was created with representation from all of KHPA's programs. The prime functions of the working group are to provide coordination of quality planning and initiatives and to identify and develop quality activities within programs and across the agency. This group meets on a regular basis every other month subject to need. A description of the Medicaid advisory groups that support KHPA's quality improvement activities is presented below.

What are the long-standing advisory groups and committees for Kansas Medicaid?

- *The Peer Education and Resource Council (PERC*) is an advisory board that assists KHPA with clinical and quality of care issues affecting HealthConnect (HCK) and Fee-For-Service (FFS) beneficiaries. The membership includes physicians, an Advanced Registered Nurse Practitioner (ARNP), and a pharmacist. Issues are addressed through peer-to-peer interaction and education with the objectives of performance improvement and greater quality of care.
- *The Medical Care Advisory Committee (MCAC*) is to provide advice to the Medicaid agency about health and medical care services. The committee membership includes representatives of the health care professions including physicians and others, members of consumer groups including Medicaid recipients and the director of the public health department. The committee will also participate in policy development and program administration.(http://edocket.access.gpo.gov/cfr_2006/octqtr/pdf/42cfr431.12.pdf). The MCAC is expected to advise the agency on quality issues that may include quality reporting and policy by providing the perspective of the partners and stakeholders represented by the membership.
- *The Quality Assurance Team (QAT)* assists KHPA in meeting the goals of improved quality care, access, education, correct billing and cost containment. This is accomplished by monitoring of issues brought by HealthConnect (HCK) and Fee-For-Service (FFS) beneficiaries and providers. This team is a partnership between the Quality Assurance and Grievance Team of the Quality section of Electronic Data Systems (EDS) and KHPA staff. The QAT strategy for providing information to meet the stated goals include gathering data by conducting utilization reviews for established patterns, instituting corrective action plans (CAPs), participating in special studies and interacting with the PERC.
- *The Data Consortium* (see Current Initiatives below) advises KHPA in the development of health data policies for the state. It is also charged with the development of indicators that support an annual assessment of health in the state. The indicators address four of KHPA's vision principles including quality and efficiency. This statewide effort will help guide KHPA in the selection of quality indicators for its specific programs, where possible, to either be consistent with statewide measures or to compliment them with program specific data.
- The Medical Workgroup conducts weekly meetings to address issues brought by program managers for Medicaid and HealthConnect. This group is comprised of the Medicaid FFS team, the HCK program manager, the pharmacy program manager, the Medicaid Medical Director, a consultant physician and the quality coordinator. Issues regarding policy, criteria, coverage, prior authorization and other program-related medical issues are the focus of this committee.

Defining Quality

The primary goal of quality improvement at KHPA is to use the resources the agency manages to purchase high quality health care for the populations it serves. In its seminal review of patient safety across the country, *To Err is Human*, the Institute of Medicine adopted Harold Van Cott's definition of quality of care, which is the "degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." The Institute of Medicine's follow-up publication, *Crossing the Quality Chasm: a New Health System for the 21st Century*, included a set of six proposed aims for improving quality in health care; that it be safe, effective, patient-centered, timely, efficient, and equitable.

In more operational terms, quality health care has been described as successfully obtaining the health care services needed, at the time they are needed, to achieve the best possible results. This definition of quality health care assumes appropriate utilization of services by avoiding underuse, overuse and eliminating misuse.

Defining and assessing quality of care is an ongoing process and may result in different quality measures across programs. However, KHPA is committed to coordinating quality measurement and health care purchasing whenever possible by seeking commonality and comparability The following are examples of measures that could serve as indicators for each of the characteristics noted in the previous description of quality health care:

- Getting the right health care – delivery of preventive and maintenance care based on practice standards for persons diagnosed with diabetes as assessed by Healthcare Effectiveness Data and Information Set (HEDIS) measurement.
- At the right time: Children are fully immunized by the age of two years.
- Using the right services: Walk-in urgent care, clinics, or physician offices are used for the assessment of earaches.
- Avoiding underuse: Increased rate of age-appropriate screening testing for colorectal cancer.
- Avoiding overuse: Reduced rate of Emergency Room visits for non-emergent health concerns.
- Eliminating misuse: Reduced use of antibiotics for upper respiratory viral infections.

Improving Quality

KHPA quality improvement efforts are intended to systematically and deliberately assess, measure and analyze quality within and across its programs. Quality monitoring is a process of periodic collection and analysis of a core set of health indicators. For KHPA programs these indicators are focused on optimal health outcomes and efficiencies. Continuous monitoring of selected indicators enables assessment of health facilities' or programs' overall functioning to ensure that desired outcomes are achieved (http://www.qaproject.org/methods/resqa.html August 28, 2008).

As mentioned earlier, KHPA will use the following strategies to identify and address opportunities for improving the quality of care provided in its health care programs:

- Regular and systematic assessment and monitoring of available quality data in the form of

a. Standardized data drawn from surveys and administrative health data.
b. Targeted analyses and special data collections.

- Identifying measures across KHPA programs to provide opportunities for consistency that will facilitate comparisons and enhance coordination of health care purchasing.
- Working with program managers and agency leadership to assess programmatic quality data that is to be made publicly available.
- Recommending quality-enhancing policies to program managers and agency leadership.

Transparency – providing detailed information about KHPA programs - is critical to effective quality improvement. Our programs provide coverage to nearly a half-million Kansans each year and disburse nearly $2 billion in health care payments to thousands of providers. Stewardship over such a large portion of the state's resources requires public oversight, trust and involvement. Transparency is an integral component of KHPA's vision principles and the agency is engaged in a broad range of activities to make program and other health information more widely available to stakeholders and the general public. KHPA values public reporting for what it serves to contribute by:

- Exhibiting accuracy and accountability in KHPA programs and MCOs
- Supporting beneficiary choice of plans and programs
- Informing stakeholders and policymakers about program strengths and needs
- Supporting better policy making
- Encouraging continuous quality improvement

The commitment to make quality information public puts Kansas in the forefront of public reporting. A 2007 study found, "Most of the states with large full-risk MMC (Medicaid Managed Care) programs are now publicly reporting some quality data by plan (17 of the 20 *states* with at least 200,000 enrollees). Conversely, states with smaller programs tended not to report (11 of 15 states)." (Felt-Lisk, Barrett, and Nyman, 2007) It is the commitment of KHPA to develop a quality approach in Kansas that will stand out among both large and small states. This approach includes publishing the managed care plan data as well as quality data from other Medicaid programs and the state employee-related programs.

Review of KHPA Quality Activities

This review describes the gaps in quality measurement and the formulation of recommendations for quality improvement initiatives in the upcoming year. Assessment of quality data includes identifying existing quality-related reports, activities and initiatives:

Current Quality-Related Initiatives

In addition to specific programmatic quality reports and data, KHPA has implemented initiatives that support and enhance the quality improvement process. These initiatives are statewide efforts and include specific measures designed to improve the delivery and quality of health care.

1. Data Consortium: this advisory group of community experts and stakeholders began meeting in December 2007. As its first major task, KHPA asked the Consortium to develop a set of measures for health indicators related to four of the six Vision Principles listed previously: (1) Access to Care; (2) Affordable, Sustainable Health Care; (3) Quality and Efficiency; and (4) Health and Wellness. Four working groups were created to complete this objective and make recommendations to the KHPA Board in calendar year 2008. Additionally a report will

be produced and delivered to the 2009 Kansas Legislature on the overall "health of the state." (http://www.khpa.ks.gov/KHPADataConsortium/Docs/DCCharterRev012208.pdf).

2. State Quality Institute: In 2008 Kansas was selected as one of eight states to participate in the State Quality Improvement Institute (SQI) organized and funded by the Commonwealth Fund and Academy Health. States that are ready or have already made a commitment to health care quality improvement were chosen following an intensive, competitive-selection effort. Kansas' quality improvement project topics are the development of medical homes for children and preventing hospitalization for asthma.

3. Medicaid Transformation Grant: Passed by Congress in 2006, the Deficit Reduction Act (DRA) authorized new grant funds to states for the adoption of innovative methods of improving effectiveness and efficiency in Medicaid. Kansas was awarded a grant within the category of Quality and Health Outcomes. The objectives of this grant address technology improvements in preventive care for disabled Medicaid beneficiaries.

4. Health Information Technology: There are two active initiatives related to promoting health information technology and exchange at the KHPA.

    a. A Medicaid Community Health Record Pilot used by providers treating beneficiaries in Sedgwick County, with a total of 40 provider sites. Providers are given secure internet access to beneficiary health records populated by claims information. Providers can access the patient record to review information such as past hospitalization, physician visits, allergies, immunizations and EPSDT forms completion, and can add to the patient record. Use of information technology in health care can lead to better coordinated care, improved health outcomes and potentially reduced health care costs.

    b. An Employer Based Community Health Record Pilot program in the Kansas City area for a sample of State Employee Health Plan members. This project utilizes the same health information technology platform as the Medicaid pilot to provide secure internet access to consumer's personal health record which is shared with providers based on consumer preferences.

5. Data Analytical Interface (DAI): The DAI is a tool that will provide desktop access for KHPA staff to health care program data from multiple sources. The DAI will significantly increase access to detailed program data at all levels of program management. Enhanced access to data is expected to enhance programmatic learning within the organization, provide more comprehensive surveillance of medical trends and outcomes and assist in the development of health policy. Use of the DAI will improve program enhancing, closer monitoring and assessment of policy impacts.

6. Medicaid Transformation: The KHPA board convened a subcommittee to oversee Medicaid transformation in June 2008 and report recommendations to the full board. The purpose of the transformation process is to assess major program and services areas with the objective of improving efficiency and quality and to identify trends in expenditures. As part of the transformation process program managers reviewed 14 programs and service areas generating written reports with recommendations for changes for the upcoming year. The program reviews will be published in the January 2009.

Although included in the Medicaid transformation process, this program review is intended to evaluate quality improvement efforts across all of the agencies' health care programs.

Quality-Related Activities In KHPA's Health Care Programs

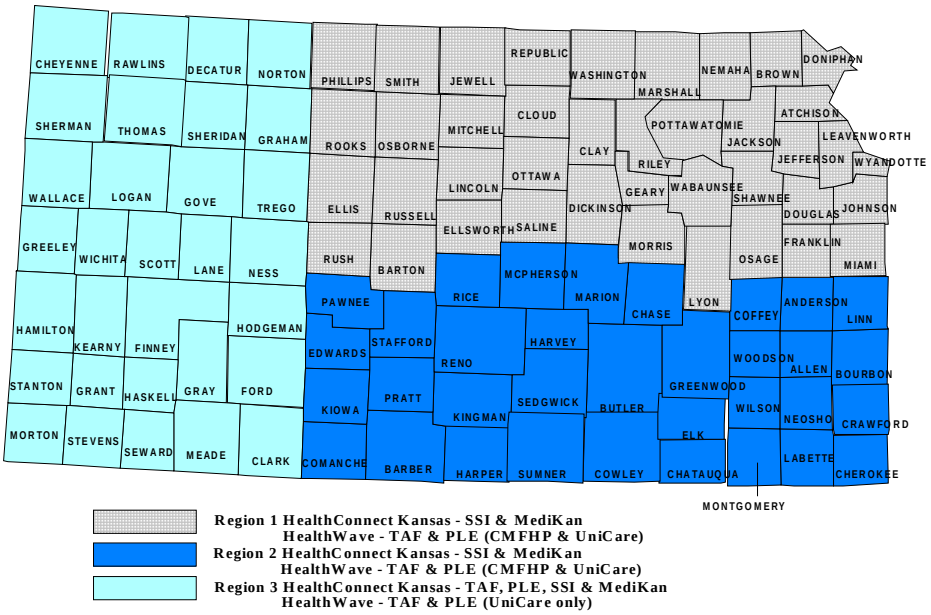
Medicaid and HealthWave

HealthWave – Capitated Managed Care Organization System: The Medicaid Managed Care (MMC) program and the State Children's Health Insurance Program (SCHIP) were merged in 2001 into the HealthWave program, creating a seamless product which allows families receiving services through more than one program to have the same health plan and/or provider. The HealthWave program also serves parents and children who are eligible under Temporary Assistance to Families (TAF) and Poverty Level Eligible (PLE) programs.

HealthWave is administered as a capitated Managed Care Organization (MCO) program in three "regions" across the state. Regions 1 and 2 cover the eastern two-thirds of the state and region 3 covers the western one-third (Figure 1). In regions 1 and 2, HealthWave eligible members may chose between two MCO plans. In region 3 there is a single MCO plan and a Primary Care Case Management (PCCM) plan called HealthConnect Kansas (HCK), described below. Since January 2007, KHPA has contracted with two MCOs to provide coverage for HealthWave beneficiaries. UniCare Health Plan of Kansas serves all three regions statewide, while Children's Mercy Family Health Partners serves Regions 1 and 2.

Figure 1

HealthWave Regions



Federal oversight requirements for MCOs are summarized in the Code of Federal Regulations (CFR): Title 42 § 438.352. Based on these requirements, the state monitors and performs oversight for quality data on a regular and systematic basis and conducts annual reviews of the MCO plans. The CFR requires validation of specific aspects of our programs by an External Quality Review Organization (EQRO) to ensure quality and regulatory compliance. The EQRO validates a sample of measures from Healthcare Effectiveness Data and Information Set (HEDIS), and also validates the study design and sample selection for the Performance Improvement Projects.

The state and the EQRO perform programmatic monitoring, audits; and data validation to identify trends and concerns and to highlight successes in the managed care programs. The external quality review analyzes and evaluates data to provide information about access, timeliness and quality of care that an MCO or Prepaid Inpatient Health Plan (PIHP) or their contractors provide to Medicaid recipients. The following reports, surveys, and data are used by KHPA to assess the performance of our two MCOs serving the HealthWave population.

Quality aspects that are monitored in the MCO plans include:

- Customer Service/Satisfaction:
  - Call center statistics reports
  - Grievance and appeals reports
  - Performance improvement projects (PIP)
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey (Appendix B)
  - Provider Satisfaction Survey
  - Comparison Report: The EQRO produces a report of the (CAHPS®) results comparing the HealthConnect Kansas (HCK) product and the MCO plans.
- Providing Quality Care:
  - Reporting of CMS required Health Employer Data Information Set (HEDIS®) Measures (See Table B),
  - Child Immunization Rate Study – The Immunization Rate Study utilizes a combination of Medicaid and SCHIP fee-for-service claims, MCO encounters, and Kansas Immunization Registry data to develop a HEDIS-like Immunization Rate
  - Kan Be Healthy (KBH) screening monitoring
- Getting Care/Access:
  - Provider network reports
  - Access monitoring
  - CAHPS®

Table B
CMS-Required HEDIS Measure Calculations

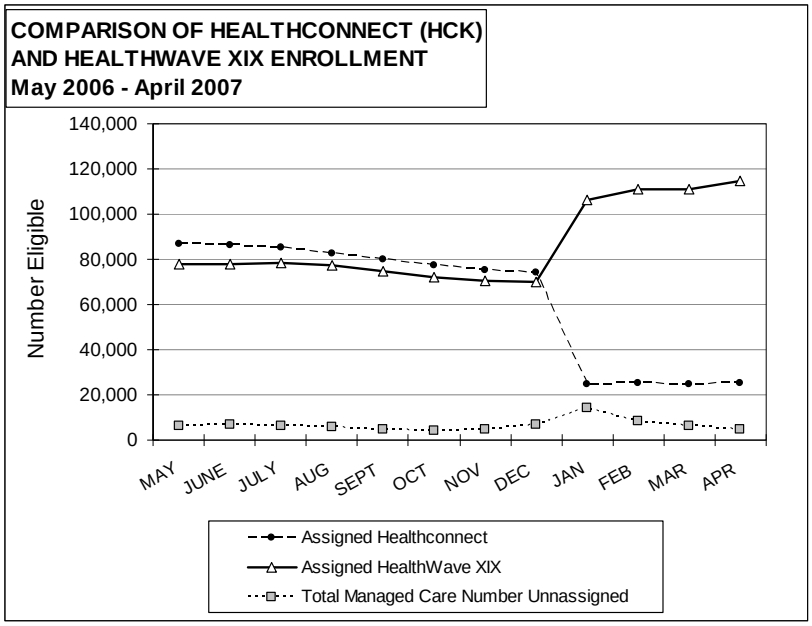
		XIX	XXI
Adult access to preventive/ ambulatory health services			
	20-44	✓	
	45-64	✓	
	65+	✓	
Comprehensive diabetes care			
	HbA1c testing	✓	✓
	Poor control HbA1c	✓	✓
	Good HbA1c	✓	✓
	Eye Exam	✓	✓
	LDL-C Screening	✓	✓
	LDL-C <130	✓	✓
	LDL-C<100	✓	✓
	Diabetic nephropathy	✓	✓
	B/P monitor	✓	✓
Prenatal Care		✓	✓
Postpartum care		✓	✓
Children's access to primary care practitioners -			
	12-24 months	✓	✓
	25 mos-6 years	✓	✓
	7-11 years	✓	✓
	12-19 years	✓	✓
Use of appropriate medications for asthma		✓	✓
WCV in first 15 months	>6 visits	✓	✓
WCV in the 3-6 year of life		✓	✓

Existing reports will be included in KHPA's initial public quality reports. This first reporting of managed care plan data will begin with the CAHPS® surveys and other required MCO reporting as indicated in Appendix B.

HealthConnect Kansas (HCK – Primary Care Case Management (PCCM) plan: Some beneficiaries receive health care benefits through HealthConnect Kansas (HCK), our primary care case management model of care. To be eligible, beneficiaries must quality for Title XIX (S-CHIP) or for one or more of the following programs: Temporary Assistance to Family (TAF), Poverty Level Eligible (PLE) Pregnant Women and Children, Supplemental Security Income (SSI), General Assistance (GA), or the Caretaker Medical Assistance (MACM). A list of the primary-care-providers (PCP) who contract to be primary care case managers (PCCM) is available to beneficiaries. The beneficiary selects a PCCM as his/her provider. If a beneficiary does not select a provider, a provider is selected for him or her. Beneficiaries are required to receive services from their PCCM or obtain a referral from the PCCM to another provider. Services excluded from this requirement are emergency services provided in the emergency room and those services exempt from case management referral (such as obstetrical care or family planning). An HCK PCCM agrees to provide medical care to a select group of Title XIX members and is paid a monthly fee for each beneficiary assigned to him/her plus the established fee-for-service payment for allowed medical services.

Effective January 1, 2007, KHPA implemented policy changes that resulted in approximately 50,000 Medicaid beneficiaries moving from the HCK program into MCO coverage. This change decreased the HCK population by approximately 66%. Figure 2 illustrates the shift in the managed care population. Because those beneficiaries moved into MCO coverage were the youngest and generally the healthiest Medicaid beneficiaries (PLE children and pregnant women, TAF parents and children, and Caretaker medical eligible beneficiaries), beneficiaries remaining in HCK include many individuals with multiple co-morbidities including chronic diseases, disabilities and mental health conditions.

Figure 2



The quality elements that are currently monitored in HCK include:

- Customer Service/Satisfaction – Patient-centered care :
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey: This survey is administered to beneficiaries and measures access, quality of service and quality of care.
  - Provider Satisfaction Survey: This survey is administered by the EQRO to providers serving HCK members. In 2009, the EQRO will develop and administer a single survey to primary care providers for both MCOs and HCK.
  - Grievances and appeals: Customer service call centers collect information and refer members and providers to the Quality Assurance Team (QAT). The QAT investigates grievances and reports data from this process to KHPA monthly.
  - EDS Call center statistics.
  - Comparison Report: The EQRO produces a report of the CAHPS® results comparing the HCK product and the MCO plans.

- Providing Quality Care:
  - Focus studies: Ongoing calculation of the HEDIS® child immunization measure.
  - Kan Be Healthy (KBH) reports: Screening monitoring and regular well child health checks
  - CAHPS® survey selected questions

- Getting Care/Access:
  - CAHPS®
  - Access to providers survey
  - Comparison Report: The EQRO produces a report of the CAHPS® results comparing the HCK product and the MCO plans.

Some measures of HealthConnect Kansas are already evaluated by our EQRO contractor because the program is an alternative to care provided through an MCO. However, because HCK is also reimbursed through fee-for-service, there are quality measures that are currently not assessed such as HEDIS® measures, separate studies on resource utilization or record reviews for clinical quality. KHPA will be evaluating these quality measures in the future.

Medicaid Fee-For-Service – FFS: Traditional Medicaid fee-for-service (FFS) is a system of direct payments to providers for individually-billed services. The FFS system pays providers for covered services under clearly established payment criteria and includes safeguards to help prevent fraud and misuse of Medicaid services. The Kansas FFS Medicaid program is designed to maintain appropriate, effective and up-to-date coverage as well as accurate and timely payment to providers. Oversight and monitoring for service areas are performed by program managers who review data related to their programs on an ongoing basis. These quality reviews include information from formal, longstanding management and advisory groups, direct input from providers and customers, and program manager experience in directly managing services.

Current initiatives or advisory groups in FFS that promote quality include:

- Customer Service/Satisfaction:
  - Grievances and appeals: Customer service call centers collect information and refer members and providers to the Quality Assurance Team (QAT). The QAT investigates grievances and reports data from this process to KHPA monthly.
  - Call center statistics summarizing the volume and nature of contacts by customers.

- Providing Quality Care:
  - Peer Education and Resource Council (PERC) assists with clinical and quality of care issues affecting the HCK and FFS beneficiaries
  - Pharmacy management
    - the Medicaid Drug Utilization Review (DUR) program
    - the Behavioral Pharmacy Management Program
  - Surveillance and Utilization Review System (SURS) unit that audits and reviews provider claims to ensure compliance with Medicaid rules and provides utilization review for additional program needs
  - Hospital utilization review
  - Targeted program interventions and special projects undertaken by staff in conjunction with subcontractors, such as a recent effort to educate and support home health agencies to improve their processes, increase system efficiency and develop an organizational culture of quality.

KHPA modifies policy in response to feedback from one or more of these initiatives or advisory groups. Policies consist of hard-coded rules such as covered medical services, coverage criteria, eligibility criteria for specific services and payment rates. When an issue with a policy is identified, it is researched and is addressed by the program manager with potential input from other staff, subcontractors, providers, etc. The Medical Workgroup provides a forum to present policy,

coverage criteria, practice standards and quality issues. This committee also reviews activities from the Medicaid Evidence-based Decisions (MED) Project. Kansas is one of 11 states participating in governance and topic selection for the MED Project on a subscription basis. The MED Project makes high quality evidence available to the member programs by providing rigorous, evidence-based research to decision makers on clinical effectiveness and the broader impact of health technologies and clinical coverage decisions among collaborating state Medicaid programs.

Utilization of these advisory groups and initiatives is designed to ensure careful and responsive management of health care coverage in the FFS program, and it often results in program improvements. Recent examples include the use of prior authorization to insure the medical necessity of services requested in the Home Health (HH) and Non-Emergency Medical Transportation (NEMT) programs. This has resulted in improved program compliance and a reduction of Medicaid expenditures. In addition, this process has resulted in changes in the Medicaid provider manual.

Although there is a wide range of medical services managed through FFS by different KHPA programs (such as pharmacy, outpatient services, and home health) the team approach described above provides the basis for a consistent quality improvement process across programs. A systematic approach to quality improvement can further improve these processes.

The first step in developing a systematic and thorough approach to quality improvement is regular data-driven evaluation of each major fee-for-service program area. KHPA began the Medicaid Transformation process in 2008 in order to evaluate our programs and services and present the results publicly. Ten out of 14 program reviews are focused on FFS programs. Surveys, such as the CAHPS product administered to KHPA's HealthWave beneficiaries, collect information on key outcomes such as satisfaction, self-reported levels of access, customer service and timeliness as well as standardized and direct measures of quality in health care (See Appendix B for a complete list). This type of data is currently missing in Kansas' Medicaid's fee-for-service program, leaving a potential gap in knowledge about program outcomes, and preventing comprehensive comparisons across the HealthWave and HealthConnect programs. These gaps are the initial focus for enhancements in quality improvement activity and data collection recommended for FY 2010.

MediKan

MediKan is a health care program for low income adults applying for Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) – both federal disability programs. The program is available to those who do not quality for Medicaid. Eligibility is limited to 24 months, historically, which is the expected length of time for the average person to be evaluated by the Social Security Administration for disability programs, although concerns have been raised recently about delays in these evaluations in Kansas. MediKan has a reduced set of benefits (as compared to the Medicaid program) and is financed solely using state funds with no federal matching dollars. Individuals in MediKan are assigned to a primary care case manager within the HealthConnect Kansas program to manage their physical health care needs. Health care services are reimbursed on a fee-for-service basis. Mental health services are provided by the Pre-paid Ambulatory Health Plan (PAHP). Quality improvement activities for mental health services are conducted by Kansas Social and Rehabilitative Services (SRS). KHPA proposes additional data collection and quality of care evaluation for MediKan similar to that described above for as a component of the Medicaid FFS program.

State Employee Health Benefits Plan (SEHBP)

KHPA manages the State Employee Health Benefits Plan. It is composed of the State Employee Health Plan (SEHP), which administers health insurance plan for state employees and their dependents, and the State Self-Insurance Fund (SSIF), which assesses and investigates worker's compensation claims for state employees. SEHP is organized into four work groups: Health Plan Operations, Health Plan Design and Fiscal Management, Membership Services, and Wellness. KHPA, in conjunction with the Health Care Commission, contracts with insurance carriers to provide access to medical coverage, dental coverage, vision coverage and pharmacy benefits plan for qualified members. The Kansas State Health Care Commission was created by the 1984 Legislature through the enactment of K.S.A. 75-6501 et. seq. to develop and provide for the implementation and administration of a state health care benefits program. Because our SEHP is self-funded, the insurance carriers serve as administrative service organizations (ASOs). For the 2008 benefit year, the SEHP Operations provided coverage for over 90,000 lives.

Who can participate in the State Employee Health Plan?

The SEHP is designed to provide state employees, Direct Bill members (retirees) and qualified local units with high quality health care. Kansas Administrative Regulation 108-1-1 defines eligibility for participation in the State Employee Health Plan (SEHP) for state employees and retirees. Definitions and qualifying criteria for inclusion and participation by local units in the SEHP are established through regulations – K.A.R. 108-1-3 and 108-1-4. A listing of enrolled non-state entities is located on the KHPA web site at www.khpa.ks.gov. These groups include: cities, counties, townships, education, public hospitals, public mental health agencies, libraries, extension offices, and water districts.

Several quality improvement activities are currently underway and vary by carrier and/or program. Each insurance carrier offers disease management or case management services. Member participation in these options is voluntary and perceptions regarding impact or benefit from participation is unclear. The carriers are managed through contract specific deliverables. KHPA staff analyze eligibility and claims data reported by the SEHP vendors. Understanding current activities related to health care quality measurements is dependent on the validation of current data, which is to be completed by the beginning of FY 2009. The goal is to balance quality care for plan members with fiduciary responsibility. The current focus is on comparing SEHP measures to a set of national benchmarks provided by a vendor, including medication adherence ratios, medication use rates and costs per-person. These measures can be evaluated for comparisons to "other external benchmarks." Data and information from the plan databank are being used in the "development plan design" and are being applied to inform medical care issues. For example, plan data is being used to develop targeted letters concerning medication compliance and in the wellness program to aid in providing the right level of Health Care Coaching and interaction with members.

The Pharmacy Benefit Manager (PBM) under contract with the SEHP to provide prescription drug coverage (currently CareMark) provides two retrospective benefit reviews focusing on controlled substance usage and analysis of patterns in prescribing and utilization. Patterns such as polypharmacy, use of multiple prescribers and risk for adverse drug interactions are the focus. Reporting is targeted toward informing providers about patterns of prescribing that have been identified through the program.

The SEHP is a participant in an employer-based health information technology pilot of the Community Health Record. A subset of State Employee Health Plan members living in the Kansas City area

are a part of this pilot. CareEntrust Health Information Exchange (HIE) is the health record system being used. A CareEntrust Health Record collects and organizes health care visit information including medication and lab data to create a secure repository for much of what a health care provider needs to know in order to effectively treat his or her patients. Participation in this project will help to assess whether this type of information system will assist KPHA to leverage purchasing power to enhance quality, lower costs and improve efficiency. Increasing provider and member access to existing health information such as detailed records of each health claim, is expected to improve patient awareness, lower costs and significantly increase the effectiveness and timeliness of patient care. This program began April 1, 2008.

HealthQuest is the wellness program for state employees and their families, Direct Bill members, and persons qualified within non-state groups. The mission is to partner with employees to improve their health and well-being and to better manage health care costs. Incentives to encourage positive health behaviors have been implemented in 2008 and additional incentives will be implemented in the 2009 plan year. Data for this program are collected and reported by the contracted vendor. The vendor reports the following evaluation metrics to KHPA: Clinical Outcomes, Activity Based Measures, Member/Provider Satisfaction; and Financial Outcomes. Health and wellness services available in the 2008 plan year are health coaching, health screening, personal health assessments, online resources and tobacco control, weight management and stress management programs. Participation in the health screenings occurred early in the calendar year 2008 and resulted in participation of 7,956 members. As of June 22: 12,677 plan members completed the personal health assessment. The goal for participation in the 2009 plan year is to increase participation in the wellness program to 24,000 members. A second initiative is to improve linkage between screening and assessment. Premium incentives to reinforce healthy life choices – such as not smoking or quitting smoking - are being developed around use of medical benefits consistent with Value Based Benefit Design. Dental plan incentives are in progress for 2010 implementation. These are designed to link preventive service utilization to increase the percentage pay rate for reconstructive repairs.

Staff also provide customer service to state and non-state entities. Opportunities for program improvement include updating the information manuals distributed to each state agency's human resource managers, cross-training of KHPA's Membership Services staff, updating membership service staff procedural manuals, and improving collaboration between the service areas within the SEHP. Customer surveys are in the process of being administered to state, non-state members and insurance carriers to measure our member services, policies, procedures and tools. The SEHP is currently participating in a Dependent Eligibility process review to ensure only qualified dependents are covered within families. Customer service calls for Direct Bill members, all communication forms and exception requests are being routed through a single line or central location to ensure full collection of data. A system for logging the information will facilitate the analysis of aggregated data.

The State Employee Health Plan has taken many steps to improve the overall quality of its programs, but there remain opportunities for improvement. The collection of comparable data across programs is the first step to improving quality in SEHBP programs. Fusing data from worker's compensation, the health plan, and the wellness initiative would be an informative first step. Comparison with other KHPA insurance programs such as Medicaid is a key step towards the agency's statutory mission to coordinate health care purchasing and leverage improvements in the marketplace. Perhaps the most important keys in managing employee benefits are systematic collection of consumer input related to the relative ease of using SEHBP services; responsiveness of the SEHBP staff; responsiveness of contracted health care providers; and the overall perception of

value in terms of the State Employee Health Plan offering.

State Self-Insurance Fund (SSIF)

The SSIF was established by the Kansas legislature to administer claims on behalf of State of Kansas employees who report personal injury arising out of and in the course of employment (worker's compensation). Non-state groups are not covered by this fund. Employees who sustain compensable injuries from an occupational accident or disease may be entitled to the following:

- Reasonable and necessary medical treatment expenses for the related injury or illness
- Disability compensation to replace part of the wages lost due to a disability
- Survivor benefits if death results

Providing high quality medical care, prompt disability and death benefits, return to work options, and customer service to state employees covered under the Kansas Worker's Compensation Act is the mission of the SSIF. The program philosophy is to provide worker's compensation services that meet the expectations of customers, professional competency, responsiveness, fairness, cost effectiveness, consistency, accuracy and the highest ethical standards of conduct in all its operations. To improve customer service and staff efficiencies, the SSIF has engaged a preferred vendor to provide document scanning, issue claims payments and additional expertise in the management of highly complex cases. These changes have allowed SSIF staff more opportunity to focus on managing caseload and actively engage with the claimant. Other goals for the program are to provide data about risk factors, preventive actions, training and the dissimilation of data tracking the incidence of employment related injury and illness. A number of changes in the overall management of the SSIF have been implemented, and will be evaluated in 2009 to determine whether additional improvements in the program are needed.

Conclusions

This review has highlighted a number of ongoing quality improvement activities and management efforts in KHPA's health care programs. Efforts to analyze and understand each program's impact on health and wellbeing of the populations served have not been coordinated across programs. Quality-related data has been assessed in isolation and has not been shared publicly. Publicly sharing quality related data has been identified as an opportunity in directing program improvement and supporting coordinated health care purchasing.

In addition, gaps have been highlighted in available data on the quality of the care reimbursed through state funded health care programs. A continuous quality improvement approach would address these gaps by collecting and aggregating data consistently across populations and programs and by regularly analyzing trends, utilization and health outcomes. KHPA supports a structured approach to quality improvement. The quality workgroup will serve as the mechanism to direct change and implement recommendations developed as a result of this review.

Recommendations

KHPA is committed to making quality information and data available to the public and establishing a structure for continuing quality improvement.

1. Publish accurate information and program data for the public, partners and stakeholders.
    a. Publicly post information developed from the 2008 annual program reviews.
    b. Establish a phased approach for posting existing quality data.
    c. See Table C for a recommended schedule of publication.

2. Develop quality and measurements across programs, with an initial focus on gaps identified in KHPA's FFS Medicaid program and the SEHP.
    a. Conduct CAHPS® Consumer Survey (see Appendix B) in Medicaid FFS and the SEHP.
    b. Conduct a provider satisfaction survey within the FFS providers.

3. Promote the use of health information technology in the Kansas Medicaid and SEHP programs by implementing a Community Health Record for all program participants statewide.

Attachment A

Kansas Health Policy Authority Vision Principles

Created to help the KHPA to define its direction for policies and programs, and to help make decisions on allocation of resources, including both capital and people.

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

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

Affordable and Sustainable Health Care - the financing of health care and health promotion in Kansas should be equitable, seamless, and sustainable for consumers, providers, purchasers and government.

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

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

Education and Engagement of the Public - Kansans should be educated about health and health care delivery to encourage public engagement in developing an improved health system for all.

Attachment B

CAHPS® Survey Scores and Ratings

CAHPS® survey themes of composites, scores, and ratings of the experiences and level of satisfaction consumers encountered with their medical care and health plan are as follows:

Composites
- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service
- Shared Decision Making (Adult Only)
- Courteous and Helpful Office Staff (Child Only)

Additional CCC Composites
- Access to Prescription Medicines
- Access to Specialized Services
- Family Centered Care: Personal Doctor or Nurse Who Knows Child
- Family Centered Care: Shared Decision Making
- Family Centered Care: Getting Needed Information
- Coordination of Care

Ratings
- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often
- Rating of Health Plan

Question Summary Rates
- Health Promotion and Education
- Coordination of Care

Questions Involving Access, Quality, and Timeliness

Access
- Getting appointments with specialists
- Getting care, tests, or treatment you thought you needed through your health plan
- Getting a personal doctor or nurse you are happy with
- Getting a referral to a specialist you needed to see
- Getting the care, tests, or treatment you or your doctor believed necessary
- Delays in health care while awaiting approval from health plan
- Doctor's office staff being as helpful as you thought they should be
- Getting the help needed when calling the health plan's customer service
- Getting your child's prescription medicine (CCC only)
- Getting special medical equipment for your child (CCC only)
- Getting special therapy for your child (CCC only)
- Getting treatment or counseling for your child (CCC only)

Quality
- Doctors listening carefully to you

- Doctors showing respect for what you had to say
- Doctors spending enough time with you or your child
- Customer service staff treating you with courtesy and respect
- Rating of health care
- Rating of specialist
- Rating of personal doctor
- Doctors explaining things in a way you or your child could understand
- Understanding information in the written materials or on the Internet
- Doctors talking to you about the pros and cons of health care treatment choices
- Finding and understanding information
- Understanding health plan paperwork
- Doctor or nurse talking with you about your child is feeling, growing and behaving (CCC only)
- Doctor or nurse understanding how health conditions affect your child's daily life (CCC only)
- Doctor or nurse understanding how health conditions affect your family's daily life (CCC only)

Timeliness

- Getting an appointment as soon as you wanted, when care was not needed right away
- Getting care as soon as you thought you needed, when care was needed right away
- Taken to exam room within 15 minutes of appointment time
- Getting the help or advice needed when calling during regular office hours
- Getting specific information you needed from child's doctor or other health providers (CCC only)

Attachment C

Current 2007– 08 Report-able Quality Data

REPORTABLE QUALITY DATA	HW	HCK	FFS	SEHP	SSIF	POSTING
Consumer Assessment of Healthcare Providers and Systems Survey	X	X		X		Spring
Provider Satisfaction Survey	X	X				Spring
Child Immunization Rate Study		X				Summer
Health Employer Data Information Set (HEDIS) Measures report	X					Fall
KBH Screening Monitoring	X	X				
Provider Network Report (PCPs, Hospitals, Pharmacies, and Specialists)	X		NA			Quarterly
Monitoring Access to PCP	X	X				Quarterly
Numbers of Grievances and Appeals	X	X	X			Quarterly
Pharmacy Ranking Reports: • Generic Drug Name • Strength • Dosage Form • Generic Code Name (GCN) • Number of Prescriptions Paid • Dollars Paid • Number of Members who Received the Prescription • Paid Amount per Claim • Average Paid Amount Per Claim	X	X*	X*			Quarterly
Wellness program Activity-Based Measures				X		Quarterly

References

Felt-Lisk, S., Barrett, A., Nyman, R. (2007). Public reporting of quality information on Medicaid health plans. *Health Care Financing Review*. 28, 5-16.