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Testimony on:

Updates on the National Provider Identifier and Data Analytic Interface Projects

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Introduction

Good morning Mr. Chairman and members of the Committee. I am Marci Nielsen, Executive Director of the Kansas Health Policy Authority. I appreciate the opportunity to update the Joint Committee on Information Technology regarding the Kansas Health Policy Authority's activities.

The Authority has taken on a number of initiatives over the past months since we became a new independent agency in July of this year. In addition to developing and approving our first budget in an abbreviated time period the agency has:

- Reorganized to reflect an increased focus on financial and budget responsibility and sustainability, promoting Scott Brunner to the new Chief Financial Officer;
- Collaborated with the Kansas Hospital Association and the Health Care Assessment Panel to ensure the Provider Assessment approved from CMS last year is considered a top priority in any reforms to the Kansas Medicaid Program;
- Developed a new website, which is updated daily, to better inform consumers, providers, and purchasers about our programs and policies. This website includes detailed information about the Health Policy Authority Board's progress, including a summary of three recent town hall meetings we conducted across the State;
- Developed a Center for Medicare and Medicaid Services (CMS) audit and deferral work plan in close collaboration with the Governor's office, our partner Executive Agencies, and the CMS Regional Office in order to resolve outstanding administrative and payment issues; Dr. Barb Langner will be the Project Manager;
- Hired a new general counsel, Marta Fisher Linenberger, and a new Director for the State Employees Health Benefits (SEHBP) program, L.J. Frederickson;
- Conducted our first policy planning meeting for hospitals who receive Disproportionate Share for Hospitals (DSH) in order to ensure that the State formula that provides DSH funding is equitable to hospitals who serve Medicaid and uninsured patients;
- Analyzed health promotion and disease prevention data from the SEHBP plan and met with leaders from other States in order to begin planning for our shift in focus from health care services to improved health status in Kansas;
- Created a Deficit Reduction Act (DRA) Interagency Planning Group to consider new flexibilities for developing a Medicaid Reform plan for Kansas;
- Developed a weekly employee newsletter to better communicate with and engage our employees, began quarterly "town hall meetings" with employees, and conducted a survey to ensure that we are creating a

productive and rewarding work environment;
- Made numerous presentations to – and had numerous discussions with – multiple Kansas stakeholders including physicians, hospitals, nurses, public health professionals, mental health advocates, etc. regarding health policy initiatives;
- Signed new contracts for Medicaid managed care with two contractors, which will save the State between $10 and $15 million annually;
- Submitted six grant proposals for the Medicaid "transformation grants", which were authorized by the Deficit Reduction Act of 2005 (DRA), to fund research and design of ways to transform the Medicaid system, increasing quality and efficiency of care.

In terms of a vision and broad goals for the Authority -- which is in the purview of the Health Policy Authority Board -- the statute is clear. The Kansas Health Policy Authority shall develop and maintain a coordinated health policy agenda that combines the effective purchasing and administration of health care with health promotion oriented public health strategies. To assist in guiding the Authority, during recent meetings and after many spirited discussions, the Board identified overall priorities and goals for the Authority. At the October 2006 meeting, the Board adopted six Vision Principles as described below:

- **Access to Health 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.

The powers, duties, and functions of the Authority are intended to improve the health of Kansans by increasing the quality, efficiency, and effectiveness of health services and public health programs.

Two of those programs are our Medicaid and HealthWave programs, which compose the majority of KHPA's budget and daily business activities. Our dedicated staff works everyday to improve the health of Kansans through our many programs and initiatives. I'd like to introduce two KHPA senior staff members to provide you with requested updates on the federally mandated National Provider Identifier and the Authority's purchase and use of a Data Analytic Interface.

National Provider Identifier Project:

Mr. Chairman and members of the committee, I am Chris Swartz, Administrator for the Medicaid & HealthWave Programs within the Kansas Health Policy Authority. I am here today to provide an update on the National Provider Identifier Project.

Background:

Part of the national Health Insurance Portability and Accountability Act (HIPAA) of 1996 was the enactment of a National Provider Identifier (NPI). The final rule for the NPI portion of HIPAA was published January 23, 2004.

The NPI is intended to uniquely identify a health care provider in standard transactions, such as health care claims. NPIs may also be used to identify health care providers on prescriptions, in internal files to link proprietary provider identification numbers and other information, in coordination of benefits between health plans, in patient medical record systems, in program integrity files, and in other ways.

HIPAA requires that covered entities (i.e., health plans, health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard) begin using NPIs in standard transactions by the compliance dates. The compliance date for all covered entities except small health plans is May 23, 2007; the compliance date for small health plans is May 23, 2008. As of the compliance dates, the NPI will be the only health care provider identifier that can be used for identification purposes in standard transactions by covered entities.

Kansas Medicaid is subject to these requirements, and thus, must be prepared to accept and use the NPI by the compliance date of May 23, 2007. As the Centers for Medicare and Medicaid Services (CMS) have already begun to issue NPIs (as of May 23, 2005), we also plan to accept and store these identifiers if providers begin to place them on electronic claim transactions.

This project modifies the MMIS claims payment system to allow Kansas Medicaid to use the NPI. The MMIS will then correctly identify providers and process their payments accordingly. The project will be implemented in two phases. Phase 1 will implement the capture and storing of NPI for later use in Phase 2. Phase 1 will also include design of the changes needed to process claims using the NPI.

Phase 2 will implement the end-to-end processing of transactions using the NPI.

Project Update:

Since the committee last met, Phase 1 (design) was completed in August 2006 on schedule and within budget. KHPA spent approximately $2 million on Phase 1. Federal approval for enhanced funding at 90% of cost and state approval were received for Phase 2 in early September of 2006. Phase 2 of the project is the construction and testing phase and has a proposed budget of approximately $5 million all funds. The anticipated completion date is October of 2007.

The first part of the work done in Phase 2 has been to construct and test our NPI "dual strategy." This will allow providers who submit batched electronic claims (mainly hospitals and large physician groups)

to submit both their Medicaid ID ("Legacy ID") and their NPI on Medicaid claims. This process will be available January 15, 2007. It will give KHPA and the providers a chance to begin using the NPI, to test the transactions, and to validate the crosswalk from the Medicaid ID to the NPI without impacting the claims payments.

KHPA will be able to conduct the necessary claims processing mandated by federal law on May 23, 2007, but we have had to postpone some non-essential work until after that date in light of resource restrictions. The non-essential work consists of tasks such as changes to federal quarterly reporting and work to change our fraud and abuse reporting system.

As of the beginning of November, 3,569 of the 20,000 Medicaid providers expected to obtain an NPI have reported one to us. Of those, 2,789 are physicians, advanced registered nurse practitioners, and physician assistants, 40 are hospitals, and 93 are pharmacies. The remaining 647 NPI are for a variety of other provider types such as dental, optometry, and mental health providers.

As of our last quarterly report to the Kansas Information Technology Office (KITO), covering the quarter of July through September of 2006, we had spent $146,892 of our estimated $5,966,188 budget for Phase 2.

Thank you for the opportunity to provide this update. I am available to answer any questions you may have now, or at the conclusion of the next section of testimony.

Data Analytic Interface Project Update

Mr. Chairman and members of the committee, I am Rebecca Ross, Acting Director of Data Policy and Evaluation in the Kansas Health Policy Authority. I am here today to provide an update on a new information technology project we call the Data Analytic Interface project.

Background:

The statute authorizing KHPA requires us to develop a coordinated health policy agenda and to collect and disseminate data concerning utilization and cost of health care to a variety of stakeholders. In addition, the powers and authority of the Health Care Data Governing Board (HCDGB) were transferred to KHPA on January 1, 2006. Since then, KHPA and Kansas Department of Health and Environment (KDHE) – which formerly held the responsibility for the HCDGB – have been coordinating efforts to transfer the data managed by KDHE on behalf of the HCDGB to KHPA.

The Health Care Professional Database, containing licensing information was transferred October 1, 2006. KHPA has also received hospital discharge data from KDHE and will soon be meeting with the Kansas Hospital Association to make arrangements for yearly updates to that data.

The Kansas Health Insurance Information System (KHIIS) contains data from the major health insurance carriers in Kansas, collected on behalf of the Commissioner of Insurance. Currently, that database is temporarily housed at KDHE, but it is being managed by KHPA staff. A KHIIS Manager will be on board with KHPA by the end of the year.

In addition to these health care data, KHPA also manages Medicaid and HealthWave data, as well as the data for the State Employee Health Benefit Plan.

Our statutory responsibilities for maintaining and making these data available, as well as our health policy and program management responsibilities, make it necessary for us to purchase data analytic interface software that will allow us to access all this data easily for analysis. It also in a way must permit us to share these data with appropriate partners.

Such a tool would provide the following benefits:

- Help staff respond more rapidly and capably to ever-changing questions posed by a wide range of stakeholders from CMS to the Legislature to university researchers;
- Enable staff at different levels of skill to access data at various levels of complexity by drilling down and up within the data and to share their reports with one another in meaningful ways;
- Provide a means to validate data from claims payment and encounter data systems by comparison to data from other sources;
- Make data from all the databases KHPA is responsible for managing more easily available to partner State agencies and other health care and health policy researchers; and
- Include value-added tools such as disease episode groupers or built in calculations for quality measures.

Project Update:

At their August meeting, the KHPA Board approved this project for inclusion in our FY 2008 Budget Enhancement requests. An internal team has developed an RFP that will be issued before the end of the calendar year, and a project manager has been assigned to ensure completion of all Kansas Information Technology Office requirements.

To develop the RFP, the internal team completed the following activities:

- Surveyed other states about their data warehouses combining Medicaid and other health care data;
- Visited Iowa Medicaid Enterprise to learn more about their data warehouse;
- Invited vendors to demonstrate their products and capabilities; four companies responded – Medstat, EDS, Ingenix, and Bull Services;
- Collected similar RFP's from other states, paying particular attention to states that combined data from multiple sources;
- Visited Nebraska Medicaid to learn how their interface works for them; and
- Developed a concept proposal that the KHPA Board approved at their August 15, 2006 meeting.

KHPA received approval for our High Level Project Plan from the Chief Information Technology Officer (CITO) on October 12, 2006.

An Advanced Planning Document (APD) was submitted to the Centers for Medicare and Medicaid Services (CMS) on October 30, 2006. If CMS approves the APD, we will be able to draw 90% match for implementation of the portion of the project related to Medicaid and SCHIP, and 75% for ongoing operation. If the APD is not approved, we will draw only the regular Medicaid administrative match rate of 50% for both implementation and operation.

Assuming we issue the RFP by the end of this calendar year, we anticipate award of a contract by July 2007,

with implementation completed in one year.

Thank you for the opportunity to provide this update. I am available to answer any questions you may have.