From: Dr. David Carlyle, Chairperson

To: Members of the Legislative Health Care Commission

Re: Fiscal impact of the Commission's recommendations to the Legislature

Attached is a fiscal impact analysis of the Commission's recommendation to the Legislature, prepared by the Legislative Services Agency.

Please note that I am in disagreement with the assumptions regarding recommendation number 4: *Iowa should implement a Statewide Registry*, to the extent the fiscal assumptions rest on beginning with a registry that would potentially cover the entire Iowa population. I will be discussing this with the LSA analyst who prepared the report for further clarification.

LEGISLATIVE SERVICES AGENCY
Serving the Iowa Legislature
Glen Dickinson, Director

Deborah L. Helsen
Legislative Analyst
Ola Babcock Miller Building
Des Moines, IA 50319

Phone: 515.281.6764
E-mail: deborah.helsen@legis.state.ia.us

Date: January 12, 2010
To: Members of the Legislative Health Care Commission
From: Deborah Helsen, deborah.helsen@legis.state.ia.us
Jess Benson, jess.benson@legis.state.ia.us
Joe Brandstatter, joseph.brandstatter@legis.state.ia.us
Re: Fiscal impact of the Commission's recommendations to the Legislature

Recommendation 1: Expand IowaCare to create a regional delivery model that will provide access to primary care and hospital care in the least geographically burdensome manner. This is defined as providing all but tertiary level care as close as possible to an IowaCare member's home.

As part of an IowaCare expansion, the IowaCare benefits package should be amended to include a limited pharmacy benefit. An IowaCare regional delivery model should also include provisions that will require IowaCare participating providers to continue to provide a reasonable level of uncompensated care.

Fiscal Impact: Without a framework for how a regional delivery network would be set up and implemented, the fiscal impact cannot be determined. The Department of Human Services provided a cost analysis of five different recommendations ranging from a total of $8.0 million to $42.0 million of State funds for FY 2011. Several of these options include limited pharmaceutical benefits packages. Iowa is constrained by a cap on how much federal money the State can draw down under the IowaCare program. It is estimated that the State will have a total of approximately $30.0 million per year in State and federal funding available under the cap. This means the State's share of the $30.0 million is approximately $8.0 to $10.0 million depending on the FMAP rate. Any State spending more than the $8.0 to $10.0 million would be 100.0% State funded with no federal match. To view the Department's options for IowaCare expansion including two options that are within the cap please visit:
http://www.legis.state.ia.us/lsadocs/IntComHand/2010/IHAMV059.PDF

Recommendation 2: Expand investments in technology. Invest in the technology necessary to power a more seamless system for Iowans moving from public health care to private health care coverage and for Iowans moving between public health insurance programs.

Seek new funding sources. Iowa needs to continue to aggressively seek opportunities to leverage federal funds available for Department of Human Services technology enhancements.

Deploy adequate staffing levels. State government needs to determine if it has adequate staffing levels to maintain a seamless system, and to the extent possible, add staff where necessary to promote seamlessness.

Fiscal Impact: With an anticipated expansion of Medicaid in the federal health reform legislation, the Department does not have the computer eligibility system capable of handling the influx of additional enrollees. The Department of Human Services has made a preliminary estimate that it would cost approximately $5.0 million to overhaul the eligibility system to handle the new enrollment.

The Department of Human Services may also require additional funding for computer systems upgrades to ensure that enrollees on their system can move seamlessly to the private system or from the private system back to the DHS system.

Without more information on what would be required, adequate staffing levels and a fiscal impact for a seamless system cannot be determined at this time.

Recommendation 3: Iowa should pursue early opt-in opportunities presented by federal health care reform. Iowa has a strong history of taking on a leadership role in health care access reform. If the federal government provides incentives for early adoption of measures that can increase access to affordable health care, the Commission recommends that Iowa move aggressively in pursuing these opportunities before 2014.

Fiscal Impact: The fiscal impact cannot be determined until federal Health Care Reform legislation is finalized. It is assumed that most of the early opportunities available would require some State matching funds and that the cost could be significant.

Recommendation 4: Iowa should develop a Statewide diabetic registry.

Fiscal Impact: Without a framework for how a diabetes registry would be set up and implemented the fiscal cannot be determined. The General Assembly or Commission would need to decide where the registry would be housed, who would be responsible for data processing, and exactly what data would be tracked before a cost estimate could be completed. However, based on the estimates provided by other States as detailed below, it may cost the State between $120,000 and $150,000 for implementation and operation of a registry.

The Prevention and Chronic Care Management Advisory Council in the Department of Public Health is currently working on a recommendation to establish a broader chronic disease registry that would likely encompass diabetes. The Commission may consider monitoring or participating in the work of the Council to ensure the efforts are not duplicated.

Models of diabetes registries and chronic disease registries exist in other States. For example, the Kansas Diabetes Quality of Care Project has evolved from a rudimentary data-entry collection process involving Excel spreadsheets to a central repository process via an Internet-based program. **Attachment A** has more in-depth information about Kansas' program. Currently, Kansas estimates that the cost of the registry annually is $165,000, including $68,000 for two IT contracts and $97,000 for staff time dedicated.

The State of Oregon has a statewide database for children with diabetes. Schools and providers are mandated to report Type 1 or Type 2 diabetes in children eighteen years old or younger. Adequate funding for the program is currently an issue and it is estimated that continued operation would cost the State $120,000 annually.

The State of Washington has a program called the Chronic Disease Electronic Management System (CDEMS). The System is a free electronic patient registry designed for primary care practices. Primary care practices can track multiple chronic conditions, including diabetes, cardiovascular disease, asthma, and depression. Currently, more than 150 practices in the State are using CDEMS to monitor more than 60,000 patients. From FY 2002 – FY 2005, the System cost an estimated $150,000 annually, including $100,000 for training and some development and $50,000 for 1.0 FTE position. For FY 2010, the System has a budget of $32,000. This is due to several factors, including, the introduction of electronic medical records in some clinical practices has decreased participation in the System, development resources are no longer needed and training and technical assistance are the main focus. The State's current budget situation has led to budget reductions.

Recommendation 5: Opening of the State employee pool is a concept worthy of further exploration, but not a process ready to be used. Prior to opening the State employee pool to new groups, further exploration is needed, including development of measures which will protect the stability of the State employee pool from both a cost and benefits perspective.

Fiscal Impact: The fiscal impact of Recommendation 5 cannot be determined. Due to the richness and high premium charge for benefits, it is likely that only high risk groups would desire to be added and would likely result in increased costs to the pool. The Insurance Division indicates that unknown risks exist to opening the State pool are real and significant and a five-year minimum commitment is justified to avoid groups that would enroll and depart the program.

Further exploration of the State pool completed by professional resources outside the Insurance Division is expected to cost about $300 per hour. Since the Insurance Division has not conducted studies similar to this, the billing cost could range between $12,000 and $18,000

Recommendation 6: Iowa needs to move towards a more seamless system for Iowans moving from public health care to private health care coverage and for moving between public health insurance programs.

Fiscal Impact: The fiscal impact of Recommendation 6 cannot be determined at this time.

Recommendation 7: Creditable Coverage. The Commission recommends that the Iowa Insurance Division and the Insurance Commissioner pursue all statutory options to improve seamlessness through increasing opportunities for "creditable coverage" in Iowa.

Fiscal Impact: The Insurance Division estimates that providing $50.00 to current enrollees in the HIPIowa program would cost $1.8 million per year. Current premiums range from $99-$1,200 based on health of the individual and deductible plan. This is based on the enrollment figure of 3,000 in the program. Another option would be to use the same $1.8 million to reduce all premiums by approximately 10.0%.

Recommendation 8: Information should be readily available to Iowans to provide details about the health care services provided by the safety net providers, specifically:

- The population served by safety net providers,
- Where safety net providers are located in Iowa, and
- What services safety net providers offer.

Fiscal Impact: The fiscal impact of Recommendation 8 cannot be determined. Some resources exist in Iowa that the Commission may want to consider upon further discussion.

The Iowa/Nebraska Primary Care Association (IA/NEPCA) is a bi-state non-profit membership association comprised of community health centers and other safety net providers in Iowa and Nebraska. The Association's website (http://www.ianepca.com/) provides information relating to locations, websites, and contact information of member community health centers in Iowa and Nebraska.

In Iowa, the 2-1-1 hotline provides callers with information relating to health and human services provided in local communities. A website also provides information and features a specific category related to health and medical services. Encouraging safety net providers to provide current information to the Iowa 2-1-1 may benefit those seeking information.

Iowa also has eighteen Community Action Agencies that are part of a larger network of agencies that provide services to low income families. The majority of the Agencies are private, non-profit organizations that network with other local organizations to enhance opportunities to serve the people in their community. They receive funding to administer programs from a variety of federal, state, local public and private sources.

Currently the Agencies focus on matters related to housing development, community investment, and economic development for low-income and elderly Iowans. Due to their active coordination of community programs, they may be considered a resource for information related to safety net providers across the State.

Recommendation 9: Iowa should begin the process of designing an Iowa exchange. The recommendation further delineates a list of questions to consider while designing the exchange, such as:

- What functions should an Iowa exchange include?
- What is the optimum exchange model for Iowa?
- Who should be included in an Iowa exchange?
- Should participation in an Iowa exchange be voluntary?
- Who should operate an Iowa exchange?

Fiscal Impact: The fiscal impact of Recommendation 9 cannot be determined. The Commission recommends that Workgroups One and Two consider the question of, "What functions should an Iowa exchange include in their respective charges?" This direction will not have a fiscal impact as the Workgroups should be able to absorb this work into their charge without incurring any additional cost. However, the intent of the specific State entity that would be in charge of the design of an exchange or whether that is the charge of the Commission is unclear.

Recommendation 10: An Iowa exchange will need to provide quality data regarding providers and plans, and data to consumers and funders on the cost of medical care.

Fiscal Impact: The fiscal impact of Recommendation 10 cannot be determined. To arrive at the full fiscal impact of providing cost and quality data to consumers, the cost of the production of data on quality and the production of data on cost, and then linking that data to an exchange must be considered. Details pertaining to what entities will produce this information and how it will be submitted to an exchange should be considered as the Commission continues discussions.

In Massachusetts, the entity that produces information regarding the quality of providers and plans is separate from the work done by the State's Commonwealth Health Connector (aka exchange). The Massachusetts Legislature created the Health Care Quality and Cost Council in 2006. Their charge was to develop a rating system and website to assist consumers in making informed decisions related to the quality of providers and plans relative to their cost. It has also evolved to create policy recommendations for cost containment. In FY 2007, the first year of implementation, the Council cost the State $1.0 million. In FY 2008, the cost was an estimated $1.6 million. For more information about the Council's services visit the My Health Care Options website at: http://hcqcc.hcf.state.ma.us/Default.aspx. For more information

about the Council visit:
http://www.mass.gov/?pageID=hqcchomepage&L=1&L0=Home&sid=Ihqcc.

Recommendation 11: The Commission should identify and prioritize those issues and public health concerns that when addressed could make the greatest impact on the health of Iowans and thereby also improve the overall level of cost of care.

Fiscal Impact: There is no fiscal impact for Recommendation 11. The Commission should be able to absorb this work without incurring any additional cost.

ATTACHMENT A

Kansas Diabetes Quality of Care – Chronic Disease Electronic Management System Project

Project Overview

The Kansas Diabetes Quality of Care Project (KDQOC) pilot was launched in 2004 by KDHE's Diabetes Prevention and Control Program (DPCP) in 95 healthcare clinic sites across the state and is currently collecting quality of care diabetes data to guide improving care for Kansans with diabetes. CDEMS, a public domain software program, is utilized at each site to collect patient and clinic level data thereby improving the health of people with chronic illness (in this case, diabetes) which requires transforming a system that is essentially reactive (responding mainly when a person is sick) to one that is proactive (focused on keeping a person as healthy as possible). There are currently about 11,000 diabetes patients in the CDEMS registry. De-identified patient aggregate data is transferred from each KDQOC Project clinic to a central repository bi-monthly providing the capability to query aggregated data from an individual clinic, group of clinics, clinics by county and all clinics statewide. Queries can also be run for selected indicators such as HbA1c levels, lipid levels, blood pressure and so on.

One of the unique aspects of this project is the variety of participating healthcare organizations. The number of diverse organizations increases the capacity to collect data across a broader demographic segment of the Kansas population. The types of participating organizations include:

- Safety Net Clinics
- Local Health Departments
- American Indian Health Clinic
- Home Health Agencies
- Hospital Affiliated Practices
- Private Practices
- Rural Health Clinics
- Farmworker Program
- Lay Health Worker Program

By reviewing CDEMS data at the patient and clinic level, providers are able to make adjustments in their practice procedures to improve the quality of care leading to better patient outcomes. The CDEMS data analysis for 2005-2008 showed improvements by 50% in almost all clinical process measures. See tables below:

Percent of Total CDEMS Patient Registry		
Clinical Goals	**2005**	**2008**
HbA1c Tests	46%	87%
Foot Exams	26%	56%
Eye Exams	19%	43%
Flu Vaccinations	18%	41%
Pneumonia Vaccinations	7%	19%
Clinical Processes	**2005**	**2008**
Patients Self Monitoring Blood Sugar	24%	46%
Diabetes Education Provided	13%	47%
Nutrition Education Provided	10%	35%
Patient Self-management Goals Set	8%	26%
Smoking Cessation Counseling Provided	5%	17%
BMI Calculated	9%	73%
Blood Pressure Checked	36%	88%

As a result of this project, individual clinics reported other improvements and innovations including:

- Lower aggregate HbA1c and cholesterol levels across the practice
- Greatly increased community awareness of diabetes issues
- Increases in average patient visits
- Patients meeting their self-management goals increased from 65% to 80%
- YMCA scholarships awarded to patients as an incentive
- Implemented quarterly chronic care and foot clinics
- Exercise physiologists added to the diabetes team
- Partnered with community leaders to develop walking trails
- Blood sugar meter fairs for providers to help them practice with new products

Data Collection and Analysis Process

The data collection and analysis process for the first year consisted of each organization sending the Kansas DPCP a hard copy of the CDEMS summary report. Kansas DPCP staff would then do a rudimentary analysis of the data that included re-keying some of the data into a Microsoft Excel spreadsheet. Because this method of data collection and analysis was very inefficient, each of the participating health care organizations were asked to export the CDEMS summary data into a Microsoft Excel spreadsheet and then submit the file electronically by email to the Kansas DPCP. The data was then merged into a master spreadsheet for analysis.

While the process had improved, there were still significant barriers. Technical assistance was required for some organizations that did not have staff with sufficient computer skills for exporting data from CDEMS to Excel. Data was often reported incorrectly and required follow-up communications. Developing multifaceted queries in Excel was challenging. And, the 300-350 health care providers participating in the DQCP were becoming increasingly frustrated with the process.

Central Repository Pilot Project

The Pilot Project was implemented initially in five of the DQCP organizations and later added eleven more to test a system for collecting CDEMS aggregate data through an Internet-based program. The Kansas DPCP contracted with a private software development company for the following scope of work:

- Develop CDEMS adapter (push program) to extract data
- Remove all patient identification data
- Transfer data to a centralized repository through a secure internet connection
- Create customized query capability to run aggregate reports on data stored in the repository

Data from each of the health care organizations and their satellite clinics was successfully transferred via a secure Internet connection on a bi-monthly basis to a centralized repository allowing the Kansas DPCP to run standard and complex queries and generate aggregate reports. This process substantially decreased the time previously spent on data entry and increased the consistency and accuracy of data collection and analysis.

The pilot demonstrated a more cost effective and accurate process for collecting and analyzing diabetes quality of care data on a statewide basis. Because the selection criterion for the Pilot was established to test the portability to all organizations in the KDQOC, the success of the Pilot has been spread to the all participating health care organizations in the Project. Plans are moving forward to add 200-400 more clinics in the immediate future.

For more information contact Kate Watson, MA, MPA, Manager, Diabetes Prevention and Control Program, Kansas Department of Health and Environment at kwatson@kdheks.gov .