

*Coordinating health & health care
for a thriving Kansas*



REQUESTED LEGISLATIVE COORDINATING COUNCIL
STUDIES
BY THE KANSAS HEALTH POLICY AUTHORITY AND
PARTNERS

January 13, 2009

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HOUSE OF REPRESENTATIVES

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July 29, 2008

Kansas Health Policy Authority

Dr. Marcia Nielsen
Executive Director
Kansas Health Policy Authority
Landon State Office Building
Room 900-N
Building Mail

Dear Dr. Nielsen:

As a result of action by the Legislative Coordinating Council (LCC) on July 9, 2008, this letter enumerates the approved studies to be conducted during this Interim by the Kansas Health Policy Authority. The LCC action is in response to a May 2008 request made by the Conference Committee on H. Sub. for SB 81 and includes a number of study topics initially considered as part of the legislation. A response from your agency is to be provided to the Joint Committee on Health Policy Oversight on or before November 1, 2008.

The study topics assigned to the Kansas Health Policy Authority are as follows:

1. *State Employee Health Care Benefits Program.* Study a requirement which would allow the employer contribution (by the State) to any HSA plan offered to state employees be equal to the employer contribution to any other state health benefit plan offered to state employees. Report on the mechanism(s) for depositing the cost savings in the employee's Health Savings Account (for both new and current employees).

2. *Medicaid reform* including, but not limited to:

Allowing the Inspector General to keep a portion of the moneys recovered from persons committing Medicaid fraud; modernizing Medicaid benefits and payment policies to encourage wellness, efficiency, and aligning Medicaid payment policies with Medicare payment policies; allowing Medical Assistance (MA) recipients whose assistance has ceased to purchase coverage for up to three years; the experience of other states; long-term care; waste, fraud, and abuse; Health Opportunity Accounts; and other reforms allowed by federal law.

Dr. Marcia Nielsen
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3. *Expanding affordable commercial insurance* including, but not limited to:

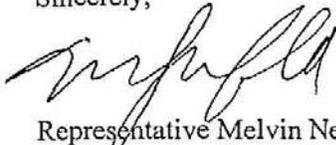
Individual and small business tax credits; encouraging HSAs, HDHPs, and section 125 plans; allowing insurers to provide incentives in return for participation in programs promoting wellness, health and disease prevention; allowing insurers to offer young adult policies with limited benefits and reduced premiums; changes to the KHIA plans and eligibility and the use of reinsurance mechanisms; small business health policies including the creation of a Small Business Health Policy Committee, allowing very small employers to obtain group health insurance, and making health insurance more affordable for small businesses and employees.

4. *Other issues of health reform* including health manpower, physical fitness in schools, transparency, and a statutory committee on health futures.

As part of its request, the Conference Committee requested that the Kansas Health Policy Authority be encouraged to work with other state agencies, associations, and interested parties to develop its final report of recommendations and findings to the Joint Committee on Health Policy Oversight.

Thank you for assisting the Kansas Legislature in the study of these important topics.

Sincerely,



Representative Melvin Neufeld
Chairman, Legislative Coordinating Council

cc: Senator Stephen Morris, Vice-Chairman, LCC
Senator Jim Barnett, Vice-Chairman, Joint Committee on Health Policy Oversight
Melissa Calderwood, Kansas Legislative Research Department

Study	Agency Author
1. SEHP HSA Contributions	KHPA ¹
2. OIG Use of Medicaid Fraud Recoupments	KHPA ²
3. Modernizing Medicaid to Promote Prevention	KHPA
4. Medicaid Buy-in for Persons Losing Medicaid	KHPA
5. Medicaid Reform in Other States	KHPA
6. Long-term Care in Medicaid Reform	Kansas Department on Aging ³
7. Waste, Fraud and Abuse in Medicaid Reform	KHPA
8. Health Opportunity Accounts in Medicaid Reform	KHPA
9. Other Medicaid Reforms Allowed by Federal Law	KHPA
10. Tax Credits to Expand Affordable Commercial Insurance	Kansas Department of Revenue
11. Encouragement of HSAs, HDHPs and Section 125 Plans	Kansas Insurance Department ⁴
12. Insurer Provision of Incentives for Wellness and Prevention	Kansas Insurance Department ⁵
13. Young Adult Policies with Limited Benefits	KHPA's Small Business Health Insurance Task Force & Kansas Insurance Department
14. Changes to Kansas Health Insurance Association Plans and Use of Reinsurance	Kansas Health Insurance Association ⁶
15. Expanding the Small Business Commercial Insurance Market	KHPA's Small Business Health Insurance Task Force
16. Health Manpower	Physician Workforce & Accreditation Task Force ⁷
17. Physical Fitness in Schools	Kansas Department of Health & Environment
18. Health Information Transparency	KHPA
19. Statutory Committee on Health Futures	KHPA

1 Testimony originally presented to the Joint Committee on Health Policy Oversight

2 OIG originally assigned authorship

3 SRS and KDOA have prepared a Kansas Long Term Care report, as directed by House Sub. for SB 365. This will be presented by both agencies after obtaining stakeholder input.

4 Delivered to Legislative Coordinating Council on January 9, 2009

5 Delivered to Legislative Coordinating Council on January 9, 2009

6 Authorship transferred from KHPA after Small Business Health Insurance Task Force did not include the High Risk Pool; delivered to Legislative Coordinating Council on January 9, 2009

7 The Task Force has a final meeting scheduled for January 23, 2009.

**KANSAS HEALTH POLICY AUTHORITY
LEGISLATIVE COORDINATING COUNCIL STUDY #1
Excerpted from Testimony Presented to the
Joint Committee on Health Policy Oversight
August 14, 2008
by
Doug Farmer, Director
State Employee Health Plan**

Senate Bill 81

During the 2008 Legislative Session there was much discussion focused on increasing the utilization of the Qualified High Deductible Health Plan. Along those lines, 2008 SB 81 required the following:

“Commencing with the 2009 PY that begins January 1, 2009 if a state employee elects the high deductible health plan and health savings account, the State’s employer contribution shall equal the State’s contribution to any other health plan offered by the state. The cost savings to the state for the high deductible health plans shall be deposited monthly into the employee’s health savings account up to the maximum annual amount allowed.”

Presently, the state contributes \$401.06 for each full time employee regardless of their plan choice (Plan A, B or C). From that amount, Plan C members receive HSA contributions of \$37.50 per pay period for single members and \$56.25 for members with dependents. The state contributes \$319.46 for each part time employee regardless of their plan choice (Plan A, B, or C). From that amount, Plan C members receive HSA contributions of \$28.13 per pay period for single members and \$42.19 per pay period for members with dependents. As the requirements of SB 81 are already being met, the KHPA does not intend to take any additional action.

**KANSAS HEALTH POLICY AUTHORITY
LEGISLATIVE COORDINATING COUNCIL STUDY #2
Allowing the Inspector General to Keep a Portion of the Money Recovered from
Persons Committing Medicaid Fraud**

Background

On July 9, 2008, the Legislative Coordinating Council (LCC) approved a number of studies be conducted in the Interim by the Kansas Health Policy Authority (KHPA). Identification of these studies was in response to a May 2008 request made by the Conference Committee on H. Sub. for SB 81. One of the studies requested was reporting on the experiences of other states using incentive payments in the Office of Inspector General (OIG) programs.

Introduction

The evolution of state Medicaid Offices of Inspector Generals is a relatively recent event. In 1987, Congress gave the U.S. Department of Health and Human Services, Office of Inspector General (HHS/OIG) authority to enforce fraud and abuse laws including anti-kickback statutes. In FY 2003, The Centers for Medicare and Medicaid Services, (CMS) started receiving funds from the Health Care Fraud and Abuse Control (HCFAC) program to help improve Medicaid Financial Management.¹ In 2006, Congress enacted the Medicaid Integrity Program, a new federal effort within CMS created under the Deficit Reduction Act to ensure program integrity in the Medicaid program. There are few comprehensive analyses of the overall program integrity challenges that Medicaid faces.² Coordination on both the state and federal level is imperative to protect and ensure efficient use of taxpayer dollars committed to the Medicaid program. Literature and data about the success of offering incentive payments for reporting Medicaid fraud and abuse is limited. Such incentive payments are not widely utilized.

Over the past 10 years, some states have combined their Medicaid Fraud and Abuse Control (MFCU) units with their Program Integrity Units, both of which are federally mandated programs states are required to establish. In some states these combined programs have become the Medicaid Office of Inspector General.

Not every state has an OIG dedicated solely to Medicaid/Medicare fraud and abuse. For example, some OIG's may focus primarily on criminal or fraudulent activities that are turned over to the MFCU. Others may choose to focus heavily on program administration, making sure publicly funded programs use funds efficiently, and ensure that program integrity and quality remain high. Some states use a combined approach. In some states, the OIG is a statewide law enforcement entity that may house an office dedicated to Medicaid fraud as part of a larger enforcement agency contained in the State's Attorney General's office.

¹ Medicaid Financial Management: *Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Effort*, United States Government Accountability Office, June 2006.

² *The New Medicaid Integrity Program: Issues and Challenges in Ensuring Program Integrity in Medicaid*, Wachino, Victoria. The Kaiser Commission on Medicaid and the Uninsured. June, 2007

Historically, efforts that focus on criminal activity are less likely to result in money coming back to the state programs or general fund. If the provider is successfully prosecuted, they are out of business and a negotiated settlement to return funds evaporates. Additionally, Health and Human Services/Centers for Medicare and Medicaid Services (HHS CMS) also enforces a rule that requires any state that identifies misappropriated funds to return the federal share of those funds back to the federal government within 60 days, regardless of the states status in collecting those funds. These funds are included on the state's quarterly CMS 64 Report. The CMS 64 report is used by CMS to assist states in reporting federal funds collected and expended for their Medicaid programs.

If the focus of an OIG is administrative oversight of state agencies and programs to ensure efficiency, to limit fraud and abuse, and ensure quality, policies that promote program integrity should be established. Stricter oversight of provider policies, procedures, and billing activities can result in savings to the Medicaid program by acting as a deterrent to fraudulent activity. However, without some additional funding source, neither criminal nor administrative activities may be sufficient to solely support an OIG budget. If funding for an OIG is solely contingent upon incentives, or a return of a portion of misappropriated funds, a return on investment should be calculated to ensure appropriate levels of funding are available to operate the office.

Current Practice in Kansas

The Kansas Medicaid program follows a number of program integrity procedures including internal and external auditing, and reporting measures required by the federal government. The agencies providing oversight and the processes in place at KHPA to ensure program integrity are detailed below:

- CMS Federal Reporting Requirements
 - Medicaid Eligibility Quality Control (MEQC) is federally mandated to monitor and improve the administration of state Medicaid programs. The MEQC unit performs reviews of Medicaid beneficiaries identified through a statistically reliable statewide sample of cases selected from eligibility files.
 - Payment Error Rate Measurement (PERM) runs parallel to MEQC, is federally mandated and designed to comply with the Improper Payments Information Act of 2002. PERM performs reviews of eligibility determinations and works closely with CMS contractors who review accuracy of claims and measure improper payments in the Medicaid and State Children's Health Insurance Programs
- U.S. Health and Human Services Office Of Inspector General Audits
 - Internal Audit Unit monitors external audits of KHPA, and provides assistance to external auditors, conducts audits and targeted reviews of KHPA operations, program and procedures, conducts consultation engagements to improve internal processes, and leads the enterprise risk management program.
- Other related activities include KHPA's Management's Medicaid program reviews for 2008 and 2009.
 - Medicaid Management's Information System (MMIS) edits and audits; SAS70 Report on MMIS controls
 - Legal Unit counsel related to the collection of third party claims (medical subrogation) and recoupment of long-term care costs from the estates of deceased Medicaid recipients.

- Fair Hearing Unit acts as the agency representative in disputes with providers or consumers relating to cases involving Surveillance and Utilization Review Subsystem (SURS) recoupment, claims processing, prior authorizations, provider enrollment and any area where an adverse action has been rendered, refers potentially fraudulent cases to SURS for review.
- Other State Agencies
 - Attorney General's Medicaid Fraud and Control Unit (MFCU), federal oversight provided by the HHS OIG. Investigates and prosecutes Medicaid provider fraud which includes false claims, false statements, kickbacks, bribes, illegal rebates, negligent and intentional failure to maintain records, and destruction of records. Prosecutes abuse and neglect of residents in residential health care facilities that are Medicaid providers, based on referrals from KHPA.
 - Legislative Division of Post Audit conducts performance audits, compliance and control audits, and financial compliance audits of Kansas government agencies, programs and activities.
- KHPA Activities
 - Surveillance and Utilization Review Subsystem (SURS) is federally mandated to monitor providers and consumers of Medicaid services.
 - SURS performs post-payment provider reviews. Consumer reviews, fraud analysis, and data analysis to safe guard against unnecessary or inappropriate use of services and against excess payments. Assess quality of services and provides control of the utilization of all services provided. SURS may impose provider sanctions such as education, recoupment, pre-pay review, withholding of payments, termination of provider agreement, and federal exclusion. Refers potentially fraudulent cases to MFCU.
 - Program Integrity Manager oversees the Kansas Medicaid state plan amendments and regulations and interagency agreements. Serves as a liaison to Social and Rehabilitation Services and Kansas Department of Aging.
- Office of Inspector General, an independent oversight body created by the Kansas Legislature in 2007.
 - Investigates fraud, waste, abuse and illegal acts committed by the KHPA and its agents, employees, vendors, contractors, consumers, clients and health care providers or other providers.
 - Performs reviews or audits of the KHPA, its employees, contractors, vendors, and health care providers to ensure that appropriate payments are made for services rendered, and to recover overpayments.
 - Monitors adherence to contract terms between KHPA and claims payment organization.
 - Networks with MFCU, SURS, the Medicaid Integrity Group (MIG), the regional health care fraud working group, KDOA, and other related groups.
 - Refers potentially fraudulent cases to MFCU.

National Survey

To report on the experiences of other states and incentive funding, six states with Inspectors General were surveyed by KHPA. New York, Florida, Kentucky, and Illinois are four states that responded to the survey. Their responses are listed below.

New York

The Office of Medicaid Inspector General was established by statute as an independent entity within the New York State Department of Health to improve and preserve the integrity of the Medicaid program by conducting and coordinating fraud, waste and abuse control activities for all State agencies responsible for services funded by Medicaid. The State of New York does not utilize incentive funding. James Sheehan, Medicaid Inspector General, voiced some concerns over the practice. The concerns he identified were based upon his experience in health care investigations and his experience with federal health care and asset forfeiture programs. His concerns are as follows:

- Incentive payments may open up an area of cross-examination for investigators and auditors by defense counsel. The Inspector General's strength is relative objectivity as state employees; this type of funding gives the defense a foothold to show bias;
- Incentive payments may give outside counsel for healthcare organizations a device to whip up hostility toward the program among their clients and state legislators. The first time the Inspector General is unsuccessful in a case, it will be heard that the agency is a "bounty hunter" just out to increase its own funding;
- The Inspector General may receive requests for documents and information about how much (incentive) is received, what is done with it, how staff are paid and promoted, whether goals or quotas are set for individuals or groups (to identify fraud and therefore collect incentive monies) which can mean increased administrative activities and costs.
- Finally, incentive payments may lead to increased media requests and scrutiny.

Florida

The Office of Inspector General is a part of Florida's Agency for Health Care Administration. The OIG oversees three areas; Internal Audits, Investigations and Medicaid Program Integrity. The State of Florida did not indicate whether the Inspector General utilizes incentive funding. However, Kenneth Yon, Bureau Chief, provided some options that may be useful to states weighing the use of incentives. These options are related to incentive funding when contracting with an independent vendor to conduct recovery efforts and identifies advantages and disadvantages of each:

- Use of time and material contracts: Contracts based upon the actual time and material used. These contracts are uncapped and may be difficult to budget for, but allows for vendor flexibility to complete the work;
- Use of flat fee contracts: Contracts based upon a flat fee regardless of the outcomes. Flat fee contracts are predictable in price, but there is less vendor flexibility to complete work;
- Contingency contracts: Contingency contracts are contingent upon vendor outcomes. In this case, payment is based on the Medicaid overpayments identified and the overpayments recovered. Contingency is much like incentive funding practices, in that it may promote vendors to pursue easy to recover "low

hanging fruit” and discourage pursuit of overpayments more difficult to recover, unless the state addresses audit specifics in the contract.

Kentucky

The Cabinet for Health and Family Services houses most of Kentucky’s human services and health care programs, including Medicaid. The Office of Inspector General, a division within the Cabinet, is Kentucky’s regulatory agency for licensing all health care, day care and long-term care facilities, and child adoption/child-placing agencies in the Commonwealth. They are responsible for the prevention, detection and investigation of fraud, abuse, waste, mismanagement and misconduct by the cabinet’s clients, employees, medical providers, vendors, contractors and subcontractors.

Kentucky Revised Statute 205.8467 addresses penalties for Medicaid providers who received Medicaid payments to which they were not entitled. Those penalties include paying for legal fees and the costs of investigation and enforcement of civil payments. Kentucky has not enforced the statute consistently, in part because the statute requires that the provider be found by a preponderance of the evidence in an administrative process to have “knowingly submitted or caused claims to be submitted for payment for furnishing treatment, services or goods....” The majority of the cases that would qualify under this statute are referred for prosecution. The state is currently reviewing the statute to see if it may be modified to make it more appropriate for those cases in which administrative action is the preferred course of action.

Illinois

The State of Illinois does not currently utilize any incentive funding programs.

Fiscal Impact and Cost Recovery Efforts across States

States report to CMS annually on OIG activities. These reports reflect agencies as varied as each state’s Medicaid program. No two states use the same methods to collect funds, collect the same data, nor do they have the same staffing configurations. For example, some state’s OIG have vast enforcement authority that is integrated into their State’s Attorney General’s office. Some have much fewer staff which may include only Medicaid Program Integrity staff, who works in conjunction with Medicaid Fraud and Control Unit (MFCU) staff located in a separate Attorney General’s office. Consequently, comparing Medicaid Fraud and Abuse cost savings, cost avoidance or effects of deterrence to measure one state’s recoupment success or audit methodology against another in a meaningful manner is difficult. Below are methods that some selected states utilize to identify and collect funding lost through fraud and abuse in Medicaid programs.

Maryland

Located in the Department of Health and Mental Hygiene, the OIG works to protect the integrity of the Department and promote standards that benefit the citizens of Maryland and program beneficiaries.

For FY 2008, the External Audits unit completed 28 audit reports of health care providers and audited 910 grants administered by the Department of Health and Mental Hygiene (DHMH) units totaling over \$274 million. These audits rendered 115 audit findings and recommendations. These findings ranged from inadequate controls over the cash receipts to untimely deposit of collections. As a result of its reviews the net amount due to the State was \$735,855.

In addition to calls made to its referral hotline, the Program Integrity Unit develops cases through data analysis provided by the SURS unit. When a unit receives a report of provider fraud, waste or abuse, the unit conducts a billing review of the provider. At the conclusion of the review the unit issues a report to the DHMH program that paid the claims under review. If appropriate, the report recommends to the paying program that it recover inappropriately paid funds from the provider. The Program Integrity Unit also refers certain cases to the Medicaid Fraud Control Unit of the Office of the Inspector General for prosecutorial review. In FY 2008, the Program Integrity Unit activities reflected a cost savings of \$20,952,007.³

Texas

The Health and Human Services Office of Inspector General was created by the Texas Legislature and works to prevent and reduce waste, abuse and fraud within the Texas health and human services system.

Total recoveries for State Fiscal Year (SFY) 2007 were \$418,079,369 (all funds). Recovery dollars are defined as actual collections recoupments, or hard dollars saved by OIG. Recoveries, as reported by OIG, do not include any other type of “soft money” or future settlement payments.

The state utilizes cost avoidance methods. Cost avoidance is a reduction to a state expenditure that would have occurred or was anticipated to occur, without OIG intervention. Cost avoidance dollars are calculated differently by business function. OIG takes a conservative approach in reporting these dollars. Some of the methodologies by business function used to calculate cost avoidance include:

- Sanctions - cost avoidance dollars are estimated savings to the state Medicaid program, which result in administrative action and/or imposing a sanction against a Medicaid provider.
- Third Party Resources - these are actual claim denials in which the provider was identified as having other insurance for which the provider was required to bill prior to billing Medicaid.
- Audit - cost avoidance results for four types of audit activities.
 - ✓ Cost report review through desk reviews and performance audits
 - ✓ Contract audit
 - ✓ Medicaid/CHIP audit through oversight and consulting
 - ✓ Outpatient Hospital/MCO Audit through desk review and performance audit⁴

Illinois

In December 2003, the Governor signed into law a bill which officially created the Office of Executive Inspector General for the Agencies of the Illinois Governor (OEIG). The OEIG powers and duties were expanded to include jurisdiction over all State agencies, including the state public universities and community colleges, except the Attorney General, Secretary of State, and Treasurer.

³ Maryland Department of Health and Mental Hygiene, Annual Report FY 2008, Office of the Inspector General. Accessed December 10, 2008

⁴ The State of Texas, Health and Human Services Commission, Office of Inspector General Annual Report, FY 2007 – Released September 2008. Accessed December 10, 2008.

During calendar Year 2007, the OIG realized a savings of over \$78.6 million through collections and cost avoidances. The OIG used a range of enforcement and prevention strategies to realize the savings. Prevention activities, which account for 55% of the cost savings, were:

- Provider Sanctions Cost Avoidance
- Food Stamp Cost Avoidance
- Fraud Prevention Investigations
- Long Term Care – Asset Discovery Investigations
- Recipient Restrictions
- New Provider Verification

Enforcement activities which account for 45% of cost savings included:

- Provider Audit Collections
- Fraud Science Team Overpayments
- Restitution
- Global Settlements
- Provider Sanctions Cost Savings
- Client Overpayments
- Food Stamp Overpayments
- Child Care Overpayments⁵

Summary

The creation of Medicaid offices of Inspectors General has been a relatively recent event. States with OIG's have different missions, authority, staffing, and numbers of beneficiaries served. Research did not identify states that engage in returning a portion of recovered Medicaid funds as incentive funds to their OIG. It does not appear to be a common practice. States that did respond to inquiry indicated that any funds recovered were returned to the state's Medicaid or General Fund.

Kansas follows many of the practices that other states reported to protect the integrity of Medicaid funds for public health programs. In order to identify and deter fraud, waste, abuse and illegal acts in state funded medical programs, Kansas conducts Audits, Investigations and Program Reviews.

- Financial Audits include review of financial documents and internal processes
- Performance Audits examine program economy, effectiveness or efficiency
- Investigations assess specific circumstances surrounding an allegation or incident of fraud, waste, abuse or illegal acts committed by a specific individual
- Program reviews are conducted to review program elements that are alleged to have caused fraud, waste, abuse or illegal acts

The KHPA OIG partners with other agencies that have the same goal of promoting proper use of taxpayer dollars and preventing fraud and abuse. Two Federal mandates establish requirements for KHPA as the Single State Medicaid Agency (SSM) to work cooperatively with the state Medicaid Fraud and Control Unit (MFCU), and the Statewide Utilization and Control Program (SURS). The MFCU receive referrals from the OIG when potential evidence of fraud is identified and investigation is compulsory. MFCU is a division of the Kansas Attorney General's office.

⁵ Illinois Department of Healthcare and Family Services, 2007 OIG Annual Report. Accessed December 10, 2008.

The SURS unit acts as a safeguard against unnecessary or inappropriate use of, or excessive payments for services. SURS also provides for the control of the utilization for all services provided and assesses the quality of those services. Kansas contracts with the Medicaid Fiscal Agent, Electronic Data Systems (EDS) to fulfill this federal mandate. EDS also manages the Kansas Medicaid Management Information System (MMIS). KHPA and SURS cooperate and assist MFCU, and the U.S. Attorney's Office with investigations concerning Medicaid fraud or abuse.

**KANSAS HEALTH POLICY AUTHORITY
LEGISLATIVE COORDINATING COUNCIL STUDY #3
Modernizing Medicaid Benefits and Reimbursement to Promote Prevention**

Introduction

Kansas Medicaid provides health care coverage for nearly 300,000 of our most vulnerable citizens with a budget of approximately 1.4 billion dollars. The population served by Medicaid (primarily low-income elderly, disabled, pregnant women, and children) has a high prevalence of obesity and smoking^{1,2}. These risk factors often lead to diabetes, cardiovascular disease, and cancer; chronic diseases that contribute disproportionately to the rising cost of medical care³.

The Kansas Medicaid program spends \$196 million a year on health care services related to smoking⁴ and another \$143 million on services related to obesity⁵. With the growing need to improve health outcomes and to constrain cost, states have increasingly turned their focus toward the prevention of chronic diseases and their complications.

A focus on prevention can take many forms, including reimbursement for preventive services, care management programs to prevent complications of chronic diseases, reimbursement for wellness programs, as well as incentives for beneficiaries to use preventive services. Several state Medicaid programs have developed innovative programs in an effort to influence enrollees toward healthier habits and participation in prevention and wellness programs.

Similar to other states' efforts, Kansas is focusing on using prevention methods as a way to improve the health outcomes and status of its Medicaid population. Most recently, the medical home concept and its emphasis on preventive care was one of three tenets contained in the Kansas Health Policy Authority's (KHPA) health reform package of 2007. Goals of the reform package included improving the quality of primary health care, promoting improved health status, and helping control the rising costs of health care. Among the policy options presented by KHPA to advance the medical home model in Kansas, was the recommendation to define a medical home in statute. During the 2008 legislative session, House Substitute for Senate Bill 81 was passed and this legislation defined the medical home in Kansas statute. As stated in statute, a medical home is:

“a health care delivery model in which a patient establishes an ongoing relationship with a physician or other personal care provider in a physician-directed team, to provide comprehensive, accessible and continuous evidence-based primary and preventive care, and to coordinate the patient's health care

¹ Oncology Times:Volume 25(23)10 December 2003p 59 State Medicaid Coverage for Tobacco-Dependence Treatments[Cancer-Related News from the CDC] Halpin, H A PhD; Ibrahim, J. PhD; Orleans, C T PhD; Rosenthal, A C MPH; Husten, C G MD; Pechacek, T. PhD

² Obesity Research Vol. 12 No. 1 January 2004State-Level Estimates of Annual Medical Expenditures Attributable to Obesity Eric A. Finkelstein, Ian C. Fiebelkorn, and Guijing Wang

³ <http://www.cdc.gov/nccdphp/overview.htm>

⁴ Source: The Toll of Tobacco in Kansas, Campaign for Tobacco-Free Kids

⁵ http://www.cdc.gov/nccdphp/dnpa/obesity/economic_consequences.htm

needs across the health care system in order to improve quality and health outcomes in a cost effective manner.”

Presently, KHPA is taking steps to operationalize the medical home concept using a multi-phase implementation plan. The emphasis of the medical home model in Kansas is on transforming the health care system from one that reacts when someone gets very sick, to one that provides proactive, comprehensive, and coordinated care to keep people with chronic illnesses as healthy as possible, and to help healthy people maintain their health through prevention and promotion activities.

Prevention in the Kansas Medicaid Fee for Service Program

Preventive Health Visits and Procedures

The Kansas Medicaid Fee for Service (FFS) plan reimburses providers for gender and age appropriate preventive health visits and procedures, such as colonoscopies, pap smears, mammograms, and laboratory tests. In addition Medicaid reimburses for pharmaceuticals used to treat smoking cessation and obesity.

In 2005 Kansas Medicaid increased physician professional fees. The Medicaid program implemented a provider assessment tax for hospitals in 2004. A portion of the revenue collected from the tax was used to increase provider fees including the Evaluation and Management (E&M) and other Current Procedure Terminology (CPT) codes used to bill for preventive health visits and procedures.

As Kansas Medicaid continues to develop the medical home model we will further enhance reimbursement rates for prevention and participation as a medical home.

Care Management

The majority of the beneficiaries who receive health care under the fee for service reimbursement are the aged and disabled population, individuals who account for the highest medical cost. The aged and disabled population in Kansas accounts for 33% of the Medicaid population, but 67% of total Medicaid spending. Almost half (47%) of the growth in Medicaid from FY 2007 to FY 2009 can be attributed to the aged and disabled; 39% attributed to the disabled and 6% to the aged.

The aged and disabled population is served either through HealthConnect Kansas (a primary care case management program) or the Fee for Service program. HealthConnect Kansas beneficiaries are assigned a Primary Care Case Manager (PCCM) who is responsible for managing their care while receiving a modest per member per month fee. Health care services a provider renders are reimbursed using the fee for service method.

The Enhanced Care Management (ECM) pilot project, implemented in March 2006, provides enhanced care services to HealthConnect Kansas members in Sedgwick County who have probable or predictable high future health care costs, usually as a result of multiple chronic health conditions. The project is an Enhanced Primary Case Management (E-PCCM) Model that is member centered, provider driven, and based on a successful model in North Carolina. Service is community based and culturally appropriate with the goal of connecting beneficiaries to social and health care services

already available in the community. Many of the components of the ECM project reflect aspects of the medical home model.

Eligible Medicaid beneficiaries are invited to receive services; participation in the pilot is strictly voluntary. Because this population is socially isolated, ECM staff establishes relationships with members in their homes, using creative outreach techniques. Care managers assist beneficiaries to focus on chronic health conditions, social risk factors and unhealthy lifestyle behaviors that adversely affect their health status. Intervention by ECM staff involves a holistic approach, which focuses on assisting clients in accessing resources in the community, which will improve their health conditions.

The care management team, consisting of a nurse, a social resource care manager, and a physician, provide a broad array of services. Some of these services are: assessing members' health and social needs; reviewing utilization trends; reconnecting members with their PCCM; ensuring members fill and take necessary prescriptions; teaching members how to manage their own health conditions; and assisting members with accessing community resources including safe and affordable housing, food, utility assistance, clothing, mental health and substance abuse services, credit counseling and others. The ECM program may also purchase health-monitoring equipment including digital blood pressure monitors, weight scales, and pedometers if prescribed by the Primary Care Manager (PCM).

Beginning in August 2006, ECM case managers began using the Community Health Record (CHR), a web-based application that allows authorized providers online access to claims data and health transactions regarding a person's office visits, hospitalizations, medications, immunizations, and other relevant healthcare information.

An e-prescribing component of the CHR incorporates drug information so that if there is a contraindication to the prescribed therapy, the clinician is alerted at the time of prescribing, rather than after the prescription is received in the pharmacy. ECM staff report that access to the CHR provides them with a more complete picture of the member's actual utilization of health resources that is often not reported by the member in interview.

As of August 31, 2007, there were 154 beneficiaries enrolled in the program. Preliminary assessment of the program suggests that enrollees may have used fewer acute care services when compared to a reference population in Wyandotte County. However the external evaluation of the outcome data from the first year of implementation is not complete.

ECM leadership and staff are in the process of adding data fields to the client database to assist with tracking disease management outcomes of beneficiaries with targeted diagnoses. These indicators will be used to track clinical treatment milestones that assess whether clinical treatment guidelines are being followed by the beneficiary. These indicators are: HgbA1c test recorded for beneficiaries with diabetes; using a peak flow meter for beneficiaries with asthma; cholesterol, triglycerides, and LDL checked and recorded for beneficiaries with hyperlipidemia; and monitoring weight daily and salt intake for beneficiaries with congestive heart failure (CHF).

A second pilot program is in progress, which also focuses on health outcomes in the disabled population. In February 2007 the Kansas Health Policy Authority was awarded

a Center for Medicare and Medicaid Services (CMS) transformation grant to improve preventive health care for disabled Kansans enrolled in Medicaid. Integral to achieving the outcomes of the pilot project is the use of the Ingenix ImpactPro information technology tool which allows case managers and independent living counselors to review the history of and the need for preventive health care for adult beneficiaries. Specifically, the tool uses Medicaid claims data to “flag” instances when beneficiaries need to have best practice preventive age and gender appropriate screenings (e.g., mammograms, colonoscopies) or other monitoring for chronic conditions. Once the preventive health care opportunities have been identified, case managers and independent living counselors can discuss with beneficiaries and their health care providers the importance and necessity of recommended screenings and monitoring. The overall goal of the project is to improve the provision of quality preventive health care services and quality monitoring for chronic conditions.

Four Community Developmental Disability Organizations (CDDOs) and three Independent Living Centers (ILCs) serve as the project pilot sites. Collectively they provide services to approximately 1,700 people with developmental disabilities and/or physical disabilities. The pilot began in November 2007; preliminary results are expected in early 2009.

Prevention in the HealthWave Program

In Kansas the low-income families and pregnant women are primarily served through HealthWave, our managed care program. Since January of 2007 Medicaid has contracted with two Managed Care Organizations (MCOs) to provide health care for the relatively healthy HealthWave population. UniCare a division of Wellpoint serves beneficiaries statewide and Children’s Mercy Family Health Partners (CMFHP) serves beneficiaries in the eastern two thirds of the state. The Kansas Health Policy Authority pays these organizations a capitated rate to provide health care to Kansas Medicaid beneficiaries.

The MCOs reimburse for preventive health office visits, procedures, and laboratory tests just as the Fee for Service program does. MCOs frequently reimburse providers at a higher percentage of Medicare in order to maintain access and improve their provider network. In addition to the standard preventive health visits and procedures the MCOs offer beneficiaries access to wellness programs and care management services.

Care Management

Both CMFHP and UniCare offer a nurse advice line for their members. Beneficiaries can access the lines to receive information that assists them in accessing the appropriate level of care for their medical condition. The CMFHP nurse line is operated 24/7. UniCare also provides a booklet (*Take Charge of your Health*) on how to appropriately access care and offers basic intervention for persons who access the emergency department frequently.

CMFHP offers case management for certain disease states. In particular CMFHP administers an asthma disease management program, which makes an incentive available (a code that is active with higher reimbursement) to providers who complete an asthma training program and follow the MCO’s protocol with their patients.

Wellness Programs

In addition to the traditional care management programs both MCOs encourage wellness through a number of other programs available to their members. These include:

Children's Mercy Family Health Partners

- *FirstTouch* OB program to educate and guide women through pregnancy
- Obesity/Weight Management program
- Wellness Program with health coaches
- ADHD Education Program
- Web based child health library

UniCare

- *Get Up and Get Moving!* Childhood Obesity Program for children under 12 that trains physicians how to measure and plot BMI and offers health coaching for family.
- *Healthy Habits Count for You and Your Baby*, a nurse prenatal education program
- *Healthy Habits Count for Asthma* education program focusing on coaching members to identify triggers, and institute appropriate lifestyles changes to reduce flare ups.
- *Healthy Habits Count for Diabetes* educational program focusing on diabetic care.
- *The Last Cigarette* smoking cessation program
- *Member Rewards* program which offers nominal gifts if you complete well care visits

Prevention in Other States

Implementation of Medical Homes in Other States

Increasingly, states are indicating an interest in the medical home model concept, with its focus on preventive care, as a way of improving the quality of primary health care, promoting improved health status, and ultimately helping to control the rising cost of health care. States, such as Colorado, Washington, Missouri, and Louisiana, are advancing the medical home model and passing legislation to organize Medicaid programs around the medical home concept. North Carolina has used existing legislative authority to extend the medical home concept to its Medicaid and State Children's Health Insurance Program (SCHIP) populations. A number of states have defined a medical home in statute, such as Louisiana, Colorado, and Massachusetts.

Wellness Incentive Programs for Beneficiaries

Several states have chosen to incentivize wellness behavior by offering enhanced services to beneficiaries who follow prescribed wellness guidelines. States can seek permission to modify their Medicaid program in this way through an 1115 waiver or under the Deficit Reduction Act (DRA). Listed below are examples of states that participate in wellness incentive programs along with a description of their programs.

Florida

Florida implemented an incentive program—Enhanced Benefits Accounts (EBA)—in 2006 under an 1115 waiver. Participants receive credits for certain behaviors such as check-ups, immunizations, and involvement in weight loss programs. Members can earn up to \$125 in credits annually, which are redeemable for over-the-counter drugs, bandages and other medical products at participating pharmacies. As of March 2007, two percent of the approximately \$2 million in credits earned had been redeemed. Reasons for the low redemption rate included delays in pharmacies processing credits and difficulties locating participating pharmacies.

West Virginia

The West Virginia incentive plan has two parts: the Basic Benefit plan and Enhanced Benefit plan. Beneficiaries must opt into the Enhanced Plan, which offers programs such as weight management, smoking cessation, and mental health and substance abuse treatment. In order to receive enhanced benefits enrollees are required to sign a personal responsibility pledge stating that they will take steps to improve their health by engaging in behaviors such as regularly visiting their physician, taking their medication and avoiding seeking care at emergency departments. If beneficiaries fail to follow the agreement they are placed back into the basic plan.

By July 19, 2008 about 8 percent of eligible individuals, were participating in the Enhanced Benefit Plan. The University of West Virginia is currently undertaking an evaluation of the benefits program, with results to be released before the end of next year.⁶

Kentucky

Kentucky initiated an incentive program in nine pilot counties, for women ages 21-64 that are Medicaid eligible. Women in this age category who complete a mammogram and/or Pap test can receive a \$10 check for one test or \$20 when both tests are completed.

Kentucky also established Health Savings Accounts for enrollees. This state combines its disease management program with an incentive program for some beneficiaries. Get Healthy Accounts are used to promote wellness, self-care, and health management. The accounts are a part of the new *KyHealth Choices* program, created under the DRA, and provide incentives for beneficiaries. Beneficiaries earn incentives and enhanced benefits by successfully participating in one year of an appropriate disease management program. Kentucky Medicaid provides targeted disease management to Medicaid beneficiaries with the following diagnoses:

- Diabetes
- COPD/Adult Asthma
- Pediatric Obesity
- Cardiac – Heart Failure
- Pediatric Asthma

The limited, enhanced benefits include:

- Limited allowance for dental services not to exceed \$50;
- Limited allowance for vision hardware services not to exceed \$50;

⁶ Wellness Incentives In State Medicaid Plans: Carrots Vs. Sticks Volume 29, Issue 520, July 21, 2008 *Kelly Wilkicki*

- Five visits to a nutritionist (registered dietician) for meal planning and counseling; and
- Two months of smoking cessation through a local health department, including two months of nicotine replacement therapy.

Eligibility for the Medicaid program is tied to eligibility for the Get Healthy Benefits Program. Unlike in some state plans, individuals no longer eligible for Medicaid will no longer be eligible for Get Health Benefits.⁷

Care Management

In addition to enhanced benefit programs other state Medicaid agencies also offer care management and disease management programs to enrollees. Some states offer these services statewide, an example is Alabama. Through an arrangement with the Alabama Department of Public Health and as a part of their primary care case management, PCCM, Patient 1st, Alabama Medicaid provides case management services to Medicaid beneficiaries throughout the state. Patients are referred for intervention directly by physicians or by the Medicaid agency.

The program is designed to address:

- Frequent use of ER
- Non compliant patients
- Interaction with disease management
- Issues/patients identified by the Medicaid agency and/or the primary medical provider (PMP)

Through the Wyoming Healthy Together project, Wyoming Medicaid offers a set of specialized services that are centered on the individual and take into consideration the physician/patient relationship while offering support, education, self-management skills and resources for coping with chronic disease.

Prevention efforts focus on educating the participants and providing them with tools to assist them in making healthy lifestyle choices. The program focuses on providing members with the tools to teach healthy eating habits, smoking cessation and the importance of physical activity. The state hopes that these prevention efforts can delay many chronic diseases and disabling conditions.

Wyoming Medicaid focuses on the social context of behavioral decisions and assisting clients to develop the personal and social skills required to make positive health behavior choices. Nurse counseling reinforces information from the clients' healthcare providers and assist them in incorporating the behavior into their daily healthcare and lifestyle decisions. Results are generated through clinical interventions with continuous reinforcement through printed, web-based and verbal education and support.⁷

The Healthy Together initiative, with its focus on disease management, was first offered to Wyoming's Medicaid beneficiaries in July 2004. The program helped the state avoid

⁷ http://www.nasmd.org/issues/docs/Health_Promotion_and_Prevention_Programs.doc NASMD Trend Snapshots, November 2006

just over \$12.3 million in projected health care costs in its first reconciliation year, which ended on December 31, 2005, according to Wyoming Medicaid officials.⁸

Discussion

The projects cited above in Kansas and other states are examples of a move toward consumer directed involvement in health care in an attempt to improve health outcomes and increase participation in prevention and wellness activities. The Center for Health Care Strategies conducted a survey of state Medicaid programs in 2006 to determine how wide spread consumer directed offerings were in Medicaid. Forty-nine out of 51 state Medicaid agencies responded to the survey, a 96% response rate.

The survey looked at 17 consumer directed approaches and found that on average most states were utilizing at least four of these strategies and were planning on implementing another 1.5 by the end of the next year. The most common policies states were planning to implement were disease management and Cash and Counseling programs. Cash and Counseling programs provide recipients with a budget, out of which they purchase needed personal care services. Medicaid agencies reported that they were considering an additional three consumer-directed strategies on average for 2008 or later. Using financial incentives to encourage healthy behaviors was the approach most frequently considered. However, it is yet to be determined whether such programs increase participation in prevention or improve health outcomes.⁹

In 2007 Kansas Medicaid began a transformation process for the purpose of improving the program through a data-driven process. Program managers were asked to assess the strengths and weaknesses of their areas of responsibility, analyze trends in spending and utilization, and make recommendations for improvement based on the data. Program reviews as they are called were centered on major plan benefits in the Fee for Service Program (such as Durable Medical Equipment (DME), hospital, hospice, etc.) as well as plan reviews (HealthWave and HealthConnect) in the managed care program.

The transformation process was expanded. During the draft stage program reviews were shared with stakeholders for input and as they are completed they have been passed on to the KHPA board. The 2008 round of the transformation process will be completed in time for the beginning of the 2009 legislative session. It is the view of KHPA executive staff and its Board of Directors that Medicaid transformation is an iterative process and as such there are no proscribed set of changes that we can institute that will perfect the program. Rather as we continue the process of reviewing and analyzing Medicaid we can make incremental changes and make recommendations to continually improve.

As a result of the program reviews, KHPA staff has recommended several changes that will move Kansas Medicaid toward a focus on prevention. In Kansas, Medicaid has traditionally focused on ensuring reimbursement for preventive services but the purpose of the two pilot programs that provide care management services to the elderly and disabled population is to prevent complications in that high-risk population. Medicaid is in the process of investigating models that will allow us to expand our care management

⁸ Disease Management News: Volume 11(15) 10 August 2006 p 1 National Health Information LLC

⁹ http://www.chcs.org/usr_doc/State_Approaches_to_Consumer_Direction.pdf, State Approaches to Consumer Direction in Medicaid, Jessica Greene

programs statewide. Over the next few months the Medicaid medical director will visit providers throughout Kansas to discuss the results of the Medicaid Aged and Disabled Program Review and illicit their ideas on ways we can better manage this population.

HealthWave members receive value added services such as weight management, health education, and smoking cessation programs. At this time the Fee for Service program does not reimburse for health education programs or health care counseling unless it is in conjunction with an office visit. During the 2008 legislative session a proposal was introduced to reimburse for smoking cessation programs during pregnancy. This proposal was subsequently accepted and was to be funded as a part of the caseload process. However, no additional funding was available for smoking cessation programs during caseload.

Additionally, the Kansas Healthy Choices program (Premium Assistance) was intended to be an extension of private health insurance to low-income families using a combination of federal, state, and employer funds. The program was authorized by the Legislature and Governor in May 2007 with the signing of Senate Bill 11. Though it was slated for implementation in January of 2009, it was removed from statute by the 2008 legislature. Kansas Health Choices was designed to help control state health care spending for the poverty level population by providing broader access to preventive care, and strengthening and expanding the private markets rather than replacing them. Inclusion of a pilot on consumer driven health care, including Health Opportunity Accounts (HOAs) which allow the opportunity to provide incentives to beneficiaries seeking preventive care services, was planned.

As a result of budget constraints the Medicaid program is not requesting funding for additional services this fiscal year. We will continue to investigate strategies to include health education and wellness programs into the Fee for Service program in the future as part of our transformation process. These strategies will include incorporating prevention and health education into the criteria we utilize to operationalize the medical home concept in Kansas.

A process to define medical home was included in state statute with legislation passed during the 2008 session. KHPA has since been working with stakeholders in a process to develop an operational definition of the primary care medical home. The definition of a medical home will be a modified version of National Committee for Quality Assurance (NCQA) criteria for medical home. The medical home concept will be adopted by Medicaid and the State Employee Health Plan. An integral part of the medical home is payment for prevention.

The results of the KHPA survey on reimbursement methodology suggest that our reimbursement for professional fees is consistent with that of other state Medicaid programs. As Kansas operationalizes the medical home in the Medicaid program we will enhance reimbursement rates for preventive services and participation as a medical home.

Conclusion

As the Kansas Health Policy Authority continues the transformation process, expanding care management, and implementing the medical home concept we will continue to explore mechanisms to increase beneficiary participation in preventive activities.

**KANSAS HEALTH POLICY AUTHORITY
LEGISLATIVE COORDINATING COUNCIL STUDY #4
Medicaid Buy-in for Those Leaving Medicaid**

Background

The Kansas Medicaid program serves vulnerable populations by providing comprehensive medical coverage with very limited cost sharing. In order to qualify, adults must either be disabled, elderly, or the caretaker of at least one minor child and must meet other requirements. Among the additional requirements are Kansas residency, citizenship, and supplying a valid social security number. By far, the most restrictive requirements that applicants must meet are the financial requirements to participate in the program.

For those with very few assets (generally around \$2,000 or less) and very low income—a fraction of the Federal Poverty Level (FPL)—adults may qualify for comprehensive health care coverage. For those whose income or assets exceed the requirements, Kansas does not provide an option for them to “buy-in” to, or purchase their own, coverage through the Medicaid program. The 2008 Legislature requested that KHPA study the potential of allowing individuals leaving Medicaid the option to buy-in to it.

Assumptions

First, the question targets those who qualify for Medicaid and are leaving the program, presumably due to an increase in income; therefore, this study focuses on able-bodied adults with children who gain employment and leave the Medicaid program as a result of increased earnings. Elderly adults are covered by Medicare, so a buy-in option would not be appropriate for that group. Disabled adults already have a buy-in option through the *WorkingHealthy* program. The remaining population with few health insurance options after becoming ineligible for Medicaid due to an increase in earnings is the able-bodied adult population with children.

It should be noted that this population does not include able-bodied, non-elderly adults with no children. There currently is no Medicaid option for this population in Kansas. Given that this study is only looking at those leaving Medicaid and not any populations that have not been previously served by Medicaid, this study will not address the non-disabled, non-elderly, uninsured, childless adults.

Secondly, this study presumes that a buy-in program would include no subsidy from either federal or State funds because all public programs will have been exhausted for the covered individuals. The costs stated in the study will reflect the actual per member per month cost of covering this population in Medicaid, all of which would be born by the individual(s) covered. Given this assumption, there are no Medicaid laws or regulations that preclude the state from offering the Medicaid package to uninsured individuals or to having the Medicaid agency administer said program. The Medicaid Management Information System (MMIS) could administer claims payment and managed care assignments, although modifications made to it for this purpose would have to be financed with State dollars.

Finally, this study considers the full Medicaid benefit package being offered to people leaving Medicaid. It would be the state’s option to offer a more restricted package, but given the unlimited number of possibilities for a limited package, this study only considers the full package of benefits.

Population

Nearly one-third of all non-elderly adults in the United States live in households with less than 200% of the FPL¹. This income threshold translates to a maximum of \$2,934 gross income per month, or \$35,208 per year, for a family of three². To maintain a relatively meager existence, a family of three can easily spend \$2,000 or more per month just on basic necessities such as housing, transportation, food, utilities, clothing, and child care. Many people working at jobs that pay less than 200% of poverty do not have access to insurance through their employers. It is understandable, then, that 27% of non-elderly Kansas adults are uninsured as compared to only 8% above 200% of the FPL³.

Medicaid

In order for a non-disabled parent to meet the financial requirements for Medicaid, the family must have income that meets financial thresholds that are not directly tied to the FPL. However, the highest a family can make would be comparable to about 30% of the FPL. For a family of three, this translates to \$440 gross income per month, or about \$5,300 per year. A family of three could not have more than one person working more than 15 hours per week at the federal minimum wage of \$6.55 per hour and be eligible for this Medicaid coverage.

Once the family is eligible, however, there are some incentives to gaining full-time employment. In order to allow people to transition into employment without losing their health care coverage, Kansas Medicaid disregards 40% of earned income for these families. This means that the one person in this family of three could increase to approximately 26 hours per week at minimum wage before becoming ineligible for this Medicaid program. Kansas also disregards actual out-of-pocket child care expenses if the child care is for purposes of employment. The allowable expenses are capped at certain amounts depending on the age of the child. Because this population generally qualifies for child care subsidies and because child care expenses vary by household, they have not been included in these calculations.

At the point the family's income exceeds this program's limit; however, the adults in the family do not automatically lose Medicaid coverage. As long as their gross income remains below 185% of the FPL, the family can qualify for full Medicaid coverage for up to one full year under the transitional medical program. This group does not get the 40% earnings disregard, but child care expenses are still deducted from the gross income. This allows the family to earn up to \$2,714 per month, or nearly \$33,000 per year for a family of three. This would allow two people in the household to be employed full time at minimum wage, or to have one wage earner making about \$15 per hour. While the KAECSES eligibility system makes it impossible to obtain earnings information for this transitional medical population, it is clear that very few people leaving Medicaid get close to the 185% income limit. As such, the vast majority of adults who lose coverage because their time on transitional medical coverage has run out and their income

¹ Kaiser Family State Health Facts retrieved on December 17, 2008 from <http://www.statehealthfacts.org/profileind.jsp?ind=141&cat=3&rgn=18>.

² Kansas Economic and Employment Services Manual, Appendix F, Item F-8. Retrieved on December 17, 2008 from http://www.srskansas.org/KEESM/Appendix/F-8_ma_program_standards_05_08.pdf.

³ Kaiser Family State Health Facts retrieved on December 17, 2008 from <http://www.statehealthfacts.org/profileind.jsp?ind=141&cat=3&rgn=18>.

exceeds the maximum for other Medicaid coverage, are earning considerably less than 185% of poverty, or \$33,000 per year for a household of three.

Cost for Buy-in

Adult participants in this Medicaid population’s average monthly expenditures FY 2008 were about \$405 per member per month. Assuming a 10% administrative cost, the total cost of the plan would be approximately \$446 per member per month. For children, the average monthly expenditure is \$181 in this population group. Assuming a 10% administrative cost, the total cost of the plan would be \$200 per member per month.

Because the vast majority of the people leaving Medicaid are well below 185% FPL, their children would continue to be covered under Medicaid or SCHIP. This study will focus on the cost and likelihood that adults would choose a buy-in option upon losing Medicaid coverage.

In fiscal year 2008, the transitional medical program served an average of 6,600 people per month. The unduplicated total of people served was over 17,000. This means that approximately 10,000 people left the transitional medical program, due to the expiration of their time limit, throughout the year. Each of these individuals would be eligible to purchase medical coverage through this buy-in program. Considering the income level of most of these households, it seems likely that most individuals would be interested in purchasing coverage, but given the cost, it seems unlikely that any of them would be able to afford to purchase unsubsidized coverage.

Table 1 illustrates the percentage of monthly income a Medicaid buy-in might cost three different families.

**Table 1
Examples of Medicaid Buy-in**

FAMILY SIZE	GROSS MONTHLY INCOME	PERCENT OF FPL	MONTHLY PREMIUM	PERCENT OF GROSS INCOME
3	\$1,325	90%	\$446	34%
4	\$2,250	127%	\$902	40%
4	\$2,845	162%	\$922*	33%

*Includes \$20/month premium for SCHIP for one child

For example, a family of three with one parent working full time at minimum wage and receiving \$200 per month in child support has a gross family income of about \$1,325 per month, or about 90% FPL. For this family, the children continue to receive medical coverage under the Medicaid program. To provide health insurance coverage through the buy-in program, the family would spend about \$446 per month on premiums, or about 34% of their gross income on health insurance.

Another example might be a family of four where both mother and father work full time at minimum wage. Total gross family income is \$2,250 per month, or about 127% FPL. Again, the children are still eligible for coverage under Medicaid or SCHIP, but the total cost of insurance for both parents will be \$902 per month or about 40% of the family’s income.

A third example considers the same family with one parent having a slightly higher wage, perhaps \$10.00 per hour, and the other parent earning minimum wage. The total income in the household is \$2,845. This is about 162% FPL. The children continue to be eligible for SCHIP with a premium of \$20 per month. Insurance for both parents will cost \$902 per month. The total for the family would be \$922 per month, or nearly one-third of the family's gross income.

Conclusion

The Medicaid program provides a comprehensive benefit package to low-income wage earners. However, when the adults' income increases and time-limits have expired, no subsidized insurance options remain. There are few options for these low-income parents. While the option to buy-in to the Medicaid program would undoubtedly sound attractive to someone facing the loss of coverage, it seems unlikely that many families will be able to spend between 30% and 40% of their gross household income on insurance coverage.

**KANSAS HEALTH POLICY AUTHORITY
LEGISLATIVE COORDINATING COUNCIL STUDY #5
Medicaid Reform and State Experiences**

Background

On July 9, 2008, the Legislative Coordinating Council (LCC) approved a number of studies to be conducted during the Interim by the Kansas Health Policy Authority (KHPA). Identification of these studies was in response to a May 2008 request made by the Conference Committee on H. Sub. for SB 81. Reporting on the experiences of other states in reforming Medicaid was one of the studies identified.

Overview of State Reform

During the past several years, a number of states have begun planning, enacting, or implementing a broad array of reform efforts. These efforts vary, and are often dependent upon the political and fiscal environment; demographic characteristics, insurance market dynamics, and other economic variables that impact a state's capacity to act.¹ Examples of the types of reform being implemented or planned include:

- Comprehensive coverage expansions;
- Strategies that focus on health system issues such as cost, quality and health insurance market reform;
- Chronic care management initiatives;
- Support for health information technology; and
- Creation of new purchasing pools.

Recently, the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) conducted a survey of Medicaid officials in all 50 states and the District of Columbia. Results of the survey are for fiscal years 2007 and 2008. Findings from the survey help illustrate the variation and the extent to which states are engaging in Medicaid reform. Some of the general findings of the survey are:

- More states than in any of the last seven years, removed restrictions or adopted policies to improve or expand their Medicaid programs in FY 2007 and FY 2008.
 - Every state implemented some type of provider rate increase in 2007 and 49 states planned to increase rates for at least one provider group in 2008.
 - More than half of all states in 2007 and in 2008 made positive eligibility changes such as increasing the income limit for eligibility, expanding eligibility for a new group (e.g., foster children, persons with disabilities who are working), or streamlining or simplifying the application or renewal process.
- Few states have taken advantage of new options to change benefits or impose new cost sharing requirements allowed through the Deficit Reduction Act of 2005 (DRA). As of October 2007:
 - Eight states used, or reported plans to use, the new DRA options related to benefits (Kentucky, West Virginia and Idaho are using the flexibility for comprehensive redesign);
 - Virginia converted its existing disease management program from a voluntary "opt-in" program to a voluntary "opt-out" DRA benchmark program;
 - Washington implemented a chronic care management pilot program under DRA authority;

¹ Academy Health. *State of the States*, January 2007.

- Kansas added personal assistance services for participants in the state's Ticket-to-Work Medicaid buy-in program;
- South Carolina planned a voluntary one-county pilot "Health Savings Account" using the State Employee High Deductible Health plan as the benchmark;
- Wisconsin planned to offer a modified benefit package adapted from its largest commercial, low-cost health care plan to the BadgeCare Plus expansion population; and
- Kentucky used the DRA authority to impose higher than nominal cost sharing amounts and to make co-payments enforceable.
- States are continuing to expand home and community-based long-term care (LTC) services.
 - In FY 2007, 35 states expanded LTC services while in FY2008 46 states planned to do so.
 - The most commonly reported LTC expansion during both years was expanding existing home and community-based services (HCBS) waivers or adopting new ones. (In Kansas, an Autism Waiver was approved in September 2007 and became effective January 1, 2008. This waiver provides support services to caregivers of children with autism spectrum disorders and early intensive intervention treatment for children with autism.)
 - States are also adding Programs for the All-Inclusive Care for the Elderly (PACE). (Currently in Kansas there is a PACE program serving Sedgwick County and one serving Topeka/Shawnee County and the six surrounding counties.)
 - Thirty-one states are using the DRA "Money Follows the Person" initiative which encourages states to transition people living in institutions to the community which supports HCBS efforts. (In May of 2007, CMS awarded Kansas a \$37 million five year demonstration grant for this initiative.)
 - Nearly half (24) of the states surveyed indicated they had plans to implement a LTC Partnership Program in 2008 to help increase the role of private long-term care insurance. (In Kansas, the LTC Partnership Program was approved to become effective April 1, 2007. The initiative encourages Kansans to partner with the state-based program as they purchase qualified private long-term care insurance policies).
- States are focusing more on Medicaid quality and improvement initiatives to get better value from Medicaid expenditures – in 2008 44 states will be using HEDIS® and or CAHPS® performance data from managed care organizations to measure and provide incentives for improved performance. (In Kansas HEDIS measures are used to annually assess the HealthWave program and are reported by the managed care organizations (MCOs); KHPA and MCOs use CAHPS data to evaluate patient-centered care, assess access to care, report performance, compare the results to local, regional, and national trends, and improve quality of care.)
- At the time of this report (October 2007), 42 states were moving forward with or were developing plans to expand health insurance coverage, almost all relying extensively on Medicaid to support and finance the plans, in order to address a growing number or uninsured individuals. (The authors of this report note that the outlook for state revenue growth as well as the outcome of the reauthorization of SCHIP and federal support for these expansions will determine how far states can go in expanding coverage.)

Source: *As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2007 and 2008*, Kaiser Family Foundation <http://www.kff.org/medicaid/kcmu101007pkg.cfm>

Summary of State Reform Efforts

The *State of the States* (January 2008) report, published by Academy Health provides a closer examination of reform efforts currently being advanced by various states. The report categorizes state reform efforts as being:

- Comprehensive – reform efforts aim to provide residents with universal or near universal coverage;
- Substantial - expand coverage, include private market reforms, and launch new purchasing mechanisms; and
- Incremental - expand health coverage for subpopulations within the uninsured.

The following summaries are provided within this framework.

Comprehensive Reforms

State of Massachusetts Reform Highlights

The State of Massachusetts enacted legislation in April 2006 aimed to provide near universal health coverage for state residents. Components of the legislation included:

- *The Commonwealth Care* program to provide subsidized coverage for people with incomes up to 300% of the federal poverty level (FPL);
- *The Commonwealth Health Insurance Connector* to “connect” individuals to insurance by offering affordable, quality insurance products;
- *MassHealth* (Medicaid program) expansion to children up to 300% of the FPL;
- An individual mandate that all adults in the state purchase health insurance by 12/31/07; and
- A requirement that employers with 11 or more employees provide health insurance coverage or pay a “fair share” contribution of up to \$295 annually per employee.

Other aspects of reform that have been implemented but not specified in legislation are:

- Minimum creditable coverage (needed in order to meet the individual mandate requirement) has been defined to include “preventive and primary care, emergency services, hospitalization benefits, ambulatory patient services, hospitalization benefits, ambulatory patient services, mental health services and prescription drug coverage.”
- Affordability standards have been established to determine the subsidy levels for people enrolled in Commonwealth Care and the premium amounts for families with incomes above 300% of FPL. About 2% of the population has been exempted from the individual mandate because insurance policies that meet the affordability standards set by the Commonwealth Connector Authority are not available.
- S.2526 was signed in August 2008 in an effort to control rising health care costs. The legislation establishes a commission to develop uniform billing and coding standards, sets a goal of adopting electronic health records by 2015, emphasizes educating providers on lower-cost drugs and medical treatments, and develops measures to increase the number of primary care doctors.
- During August 2008, the Governor signed H.5022 which increases state funding for health reform.

State of Massachusetts Reform Impact

Impact on Access	Impact on Cost	Impact on Quality	Challenges
<ul style="list-style-type: none"> • Dramatic: As of March 2008, 439,000 (or 67%) of an estimated 650,000 people who were previously uninsured are now insured. 	<ul style="list-style-type: none"> • Due to the successful enrollment into the Commonwealth Care program, the costs have exceeded previous estimates. • The Governor’s budget request of \$869 million for 2009 is about \$400 million more than for 2008; this funding may still fall short. • Options being considered for raising additional revenue include increasing the tobacco tax and legislation aimed at constraining health care cost growth overall. 	<ul style="list-style-type: none"> • Goals for improving quality were identified in April 2008 and include adopting a standard measurement of annual health care spending for the state and developing a website to provide consumers with cost and quality information. 	<ul style="list-style-type: none"> • The costs of reform have been higher than expected. • As health care costs continue to rise, keeping insurance affordable will be increasingly difficult.

Source: *States Moving Toward Comprehensive Health Care Reform*. The Kaiser Commission on Medicaid and the Uninsured, http://www.kff.org/uninsured/kcmu_statehealthreform.cfm, accessed August 19, 2008.

State of Maine Reform Highlights

- The Dirigo Health Reform Act was signed into law in June, 2003; it was a comprehensive reform effort aimed at providing affordable, quality health care to every Maine resident by 2009.
- At the center of Maine's health reform was the creation of DirigoChoice, a voluntary health care plan for businesses with 50 or fewer employees, the self-employed and eligible individuals without access to employer-sponsored insurance.
- Initially, DirigoChoice was made available through Anthem; effective January 2008 Maine began contracting with Harvard Pilgrim Health Care. The program offers discounts on monthly premiums and reductions in deductibles and out-of-pocket maximums on a sliding scale fee to enrollees with incomes below 300% FPL.²
- Funding for the program includes a combination of:
 - Employer contributions
 - Individual contributions
 - One-time appropriation of state general funds
 - Federal Medicaid matching funds for Medicaid eligible individuals
 - A "savings offset payment (SOP)", a key but controversial mechanism through which assessments are issued to insurers based on savings generated by the program.

² Academy Health. *State of the States*, January 2007.

State of Maine Reform Impact

Impact on Access	Impact on Cost	Impact on Quality	Challenges
<ul style="list-style-type: none"> Enrollment was voluntary and has fallen short of what was anticipated by policy makers. As of February 2008, 23,000 individuals and a small percentage of businesses (i.e., over 725) were enrolled in Dirigo Choice.³ When compared to the estimated 124,000 uninsured Maine residents, this number is considered modest. Additionally, for low income residents, the fully subsidized Medicaid program has been more attractive than the partially subsidized DirigoChoice plan.⁴ 	<ul style="list-style-type: none"> SOP is based on savings, identified by Dirigo Health Reform, including savings associated with a reduction in uncompensated care. The state determines the savings offset payment based on “aggregate measureable cost savings.” The aggregate cost savings approved have been lower each year than expected, and revenues available to fund subsidies through DirigoChoice have been negatively impacted. The SOP payment mechanism triggered a court challenge – in June 2007, the Maine Supreme Court upheld the SOP. In April 2008, the Governor signed legislation that replaces the SOP with taxes on beer, wine, soda, and a surcharge on insurers. New funding sources are being targeted for repeal. 	<ul style="list-style-type: none"> Efforts are being made to reduce hospital costs and improve management of chronic conditions Maine’s three largest health care systems are collaborating to make electronic health records (EHR) accessible across the three systems, share information about critically ill patients in rural hospitals, and launch preventive health programs for chronic conditions (e.g., obesity, substance abuse) to reduce high cost medical interventions. Dirigo Health’s Maine Quality Forum was created to improve the quality of care. The Forum serves as a clearinghouse for best practices and information and is a resource to providers and consumers. 	<ul style="list-style-type: none"> Sustainability of the program, especially DirigoChoice Geographic and demographic characteristics – Maine has large rural, elderly and low-income populations, with many experiencing chronic health conditions. There are many small and seasonal businesses – fewer employers offer health insurance compared to other states. The program has struggled to offer broad choices of coverage due to the availability of major carriers The SOP funding mechanism has been controversial. The new funding mechanism is targeted for repeal.

Sources:

States Moving Toward Comprehensive Health Care Reform. The Kaiser Commission on Medicaid and the Uninsured, http://www.kff.org/uninsured/kcmu_statehealthreform.cfm, accessed August 19, 2008.

State of the State January 2008. Academy Health, <http://statecoverage.net/pdf/StateofStates2008.pdf>

³ The Kaiser Commission on Medicaid and the Uninsured. *States Moving Toward Comprehensive Health Care Reform.*, http://www.kff.org/uninsured/kcmu_statehealthreform.cfm accessed August 19, 2008.

⁴ Academy Health. *State of the States*, January 2008.

State of Vermont Reform Highlights

- In June 2006, comprehensive health reform legislation was passed with the goal of achieving near universal coverage by 2010 and improving health care for people with chronic conditions. Primary components of the reform are:
 - The *Catamount Health Program* – a health insurance plan for people without access to employer-sponsored insurance. Within Catamount Health:
 - Premium assistance, on a sliding scale, is provided to individuals and their dependents with incomes below 300% of the federal poverty level;
 - The monthly premium assistance cost for individuals and their dependents range from \$60 per month for those with incomes under 200% of the FPL and \$135 per month for those with incomes between 275% and 300% of the FPL;
 - Premiums for those with incomes above 300% of the FPL are \$393 for an individual and \$1100 for a family.
 - *Employer-Based Premium Assistance* – for individuals with incomes below 300% FPL, to help them pay for their employer's insurance plan.
 - *Employer Requirement* – an assessment fee of \$365 for employees who are not offered or who do not take up health care coverage and are uninsured; there is an exception for small employers.
 - *Blueprint for Health* – is a statewide initiative to improve health and health care; the premise of the initiative is that prevention and support of chronic conditions (e.g., timely and effective treatment) will result in a healthier population and reduce demand for medical services.
- Reform financing comes from multiple sources:
 - Premium collections
 - Employer fees
 - Tobacco tax increase
 - Federal matching funds through the Medicaid program
- Implementation of the plan began in October 2007.

State of Vermont Reform Impact

Impact on Access	Impact on Cost	Impact on Quality	Challenges
<ul style="list-style-type: none"> • Catamount Health was implemented Oct. 1, 2007 and will be phased in over 5 years. A major education, outreach, and enrollment campaign for all of the insurance options available has been launched. As of 12/31/07, 1,352 individuals were enrolled in Catamount Health; the enrollment target was 4,245. 	<ul style="list-style-type: none"> • In 2010, the plan is expected to cost \$60.6 million. • The original financing called for nearly half of the funding to come from the state's Medicaid "Global Commitment to Health" waiver. • The Centers for Medicare and Medicaid Services (CMS) decided to only allow federal matching funds to be used to finance premiums for individuals up to 200% FPL (instead of all Catamount enrollees up to 300% FPL). As a result, Vermont had to commit additional General Fund revenues to fund the plan. • Additional funds are being raised by the increase in the tobacco tax and remaining funds will come from the employer assessment and individual contributions. 	<ul style="list-style-type: none"> • Prevention and chronic care management are focal points of the Blueprint for Health. • These two components are considered by Vermont as being critical to slowing the rate of health care and cost growth. • Other states can look to Vermont to see if improving chronic care management can reduce the growth of health care costs and improve quality over the long-term. 	<ul style="list-style-type: none"> • Will the Catamount Health Plan prove to be affordable for low and moderate income individuals and families (especially those not eligible for premium subsidies)? • Is financing sustainable over the long-term (the state had to commit more state funds than originally planned)? • The Blueprint Health Plan focuses on prevention and chronic care management. The plan will require significant financial investment and commitment of all stakeholders.

Sources:

States Moving Toward Comprehensive Health Care Reform. The Kaiser Commission on Medicaid and the Uninsured, http://www.kff.org/uninsured/kcmu_statehealthreform.cfm, accessed August 19, 2008

Kaiser Commission on Medicaid and the Uninsured. *Vermont Health Care Reform Plan*, December 2007, <http://www.kff.org/uninsured/upload/7723.pdf>, accessed August 19, 2008.

Other States that Considered Comprehensive Proposals

- California
- Pennsylvania
- New Mexico

Substantial Reforms

State of Washington Reform Highlights

- Reform legislation was enacted in 2007.
- The legislation reflects certain aspects of the comprehensive reform enacted by other states, in particular that of Massachusetts.
- The plan aims to provide access to health care coverage for all residents by 2012.
- Key features of the reform are:
 - Funding to provide health insurance for all children by 2010.
 - SCHIP expansion from 251 to 300% FPL; full-cost-buy-in to public coverage for those above 300% FPL.
 - Creating a statewide connector, the Health Insurance Partnership, scheduled to make health insurance products available for purchase in September 2008.
 - Directing the Health Care Authority to provide grants to community health centers that work with local hospitals to reduce unnecessary emergency room visits.
 - Creating the Washington Quality Forum to address disparities in care.
 - Expanding chronic care management.
 - Directing state health agencies to change contracts and reimbursement for pay-for-performance.
 - Promote prevention.

Source:

State of the States January 2008. Academy Health, <http://statecoverage.net/pdf/StateofStates2008.pdf>

State of Washington Reform Impact

Because implementation of the reform is so new and still in progress, the impact has not yet been determined.

State of Oregon Reform Highlights

- The Healthy Oregon Act was signed in June 2007, providing a detailed timeline for developing a full-scale health reform plan for consideration during the 2009 legislative session.
- The bill established the Oregon Trust Board, tasked with gathering public input and creating a comprehensive health care plan.
- The seven member Board, appointed by the governor and confirmed by the Senate, is composed of experts in the areas of consumer advocacy, management, finance, labor and health care.
- Five subcommittees are to make recommendations on financing, delivery system reform, benefit definition, eligibility and enrollment, and federal policy issues and opportunities.
- Existing state commissions and committees are responsible for compiling data and conducting research to inform the subcommittees' decision making.
- Per a legislative mandate, the Oregon Health Trust Board must present a plan to the legislative assembly by February 1, 2008 on the potential design and implementation of a Health Insurance Exchange.
- The Exchange is to serve as the central forum for uninsured individuals and businesses to purchase affordable health insurance.
- Public meetings for stakeholders across the state are scheduled between February 2007 and October 2008.

- A comprehensive plan is to be submitted to the Governor, the Speaker of the House and President of the Senate on October 1, 2008.
- The plan will be submitted to the Legislative Assembly during the 2009 legislative session.
- Also during 2007, the governor signed the Health Kids Plan, expanding eligibility to children. Funding for the plan was made contingent upon an 84 cent increase in the state tobacco tax. The ballot initiative was not approved by voters on the November 2007 ballot. Unless an alternative source of funding can be agreed upon, the plan will not be implemented.

Sources:

States Moving Toward Comprehensive Health Care Reform. The Kaiser Commission on Medicaid and the Uninsured, http://www.kff.org/uninsured/kcmu_statehealthreform.cfm, accessed August 19, 2008

State of the State January 2008. State Coverage Initiatives, <http://statecoverage.net/pdf/StateofStates2008.pdf>

State of Oregon Reform Impact

The reform has yet to be implemented.

State of Illinois Reform Highlights

- In March 2007, Governor Blagojevich proposed “Illinois Covered” to provide affordable and quality health care to all residents.
- The proposal builds on the success of his All Kids program, the first program in the country to provide health care for all children.
- Key features of the “Illinois Covered” are:
 - A statewide purchasing pool through which small businesses and individuals without access to employer-sponsored insurance can purchase insurance coverage.
 - Premium subsidies for individuals with incomes between 100 and 400 percent of the FPL, to help them purchase insurance.
 - A new program to cover adults under poverty and an expansion of health care coverage to families up to 400% of the FPL.
- Proposed financing of the plan was through a new Illinois Covered Trust Fund, with a 3% employer assessment as the primary revenue source.
- A bill incorporating the provisions of the Governor’s proposal was introduced during the 2007 legislature session, but was not passed.
- Because the bill was not approved, the Governor sought to use his executive authority to expand health care including:
 - In October 2007, Illinois became the first state to provide free mammograms, breast exams, pelvic exams, and Pap tests to all uninsured women.
 - The Governor implemented the FamilyCare expansion through administrative order, despite legal efforts to stop the expansion (3,300 individuals have been enrolled since November 2007).

State of Illinois Reform Impact

- On April 15, 2008, a judge issued a preliminary injunction that prohibits the Governor from continuing the FamilyCare expansion.
- It is not clear whether the 3,300 enrolled individuals will be able to continue to receive health coverage.

Source: *States Moving Toward Comprehensive Health Care Reform*. The Kaiser Commission on Medicaid and the Uninsured, http://www.kff.org/uninsured/kcmu_statehealthreform.cfm, accessed August 19, 2008

State of Indiana Reform Highlights

- Adults began enrolling in Indiana's new Healthy Indiana Plan in January 2008.
- The plan, the first of its kind among the states, allows Indiana to offer a benefit package modeled after a high-deductible plan and health savings account to low-income people using Medicaid funds.
- The plan operates under a federally approved waiver.
- The plan covers:
 - Very poor and other low-income uninsured parents (22%-200% FPL).
 - Other adults (0-200% FPL) who do not have access to employer-based coverage, Medicare, or regular Medicaid.
- Benefits are provided through managed care plans and include:
 - *High-deductible coverage* – Individuals are covered for state-specific benefits up to a \$300,000 annual cap and a \$1 million lifetime cap after meeting a \$1,100 deductible.
 - *POWER Account* – This account is used to cover the \$1,100 deductible. The account consists of monthly contributions made by the enrollees in addition to a state contribution. The state's contribution varies according to a sliding scale based on the participant's financial ability to contribute. If any funds remain in the POWER Account at the end of the year, this balance rolls-over to the following year's contributions if the participant has received the preventative services required by the plan.
 - *Preventive care* – Individuals are covered for preventive care; this care is not subject to a deductible and does not draw from the POWER Account.
- Enrollees Contributions:
 - The monthly POWER Account contributions that enrollees make range from 2%-5% of their income and are based on a sliding scale.
 - The state (in addition to federal match funds) pays for the gap between the enrollees' contribution and the \$1,100 deductible for the POWER Account.
 - If the enrollee misses a monthly payment, he or she loses coverage, forfeits 25% of his or her contributions to the POWER Account, and is barred from re-enrolling for 12 months.
- Financing:
 - As a Medicaid waiver program, Indiana must demonstrate budget neutrality.
 - The state plans to offset the coverage expansion by:
 - Using a portion of their Disproportionate Share Hospital (DSH), and
 - Achieving savings in existing Medicaid coverage for pregnant women, children, and parents covered through Medicaid.
- In addition to the savings required for budget neutrality, the state has agreed to achieve further savings of \$15 million (state and federal) over the five-year waiver period.

State of Indiana Reform Impact

- Approximately 13,000 adults were enrolled as of June 2008.
- Enrollees tend to be:
 - Poor (69%)
 - Women (65%)
 - Age 40 or older (58%)
 - Without dependent children (59%)
- Enrollment for adults without dependent children is currently capped at 34,000.
- The state estimates it will eventually enroll 86,000 parents.
- Key issues for consideration are:
 - The affordability and adequacy of the coverage;

- Enrollees' understanding of the coverage;
- The plan's ability to promote personal responsibility, cost transparency, and preventive care;
- Cost-effectiveness; and
- The impact on already eligible Medicaid beneficiaries.

Source: Kaiser Commission on Medicaid and the Uninsured. *Summary of Healthy Indian Plan: Key Facts and Issues*, June 2008, <http://www.kff.org/medicaid/upload/7786.pdf> , accessed August 19, 2008.

State of Wisconsin Reform Highlights

- BadgerCare Plus was launched on February 1, 2008; it merges Family Medicaid, BadgerCare, and Healthy Start to form a comprehensive health insurance program for low income children and families.
- Under BadgerCare Plus, eligible populations are:
 - All children, regardless of income; sliding scale premiums will be required for those above 200% of the FPL;
 - Pregnant women with incomes up to 300% FPL;
 - Parents and relatives caring for a child up to 200% FPL;
 - Regardless of income, young adults in foster care who turn 18 on January 1, 2008, will be automatically eligible for BadgerCare Plus, until they turn 21;
 - Farm families and other families who are self-employed may be eligible if their income is under 200% FPL; and
 - Parents whose child/children are in foster care and have a reunification plan in place may be eligible if their income is below 200% FPL.
- Enrollee Costs:
 - Families with incomes that exceed 200% FPL will be able to purchase basic health care for their children for \$10 to about \$68 per child per month, depending on their income.
 - Premium costs for families with incomes up to 300% FPL will be subsidized.
 - CMS approved a waiver that allows federal match for children up to 250% FPL while those between 250 and 300% FPL will be subsidized with state-only funds.
 - Families with incomes above 300% FPL are required to contribute the full cost of coverage.

State of Wisconsin Reform Impact

Wisconsin's reform plan has been in effect less than one year; the impact of the reform will take some time to realize. It is interesting to note, however, that six weeks after launching the program, 71,000 people were enrolled, far exceeding enrollment expectations.

Sources:

States Moving Toward Comprehensive Health Care Reform. The Kaiser Commission on Medicaid and the Uninsured, http://www.kff.org/uninsured/kcmu_statehealthreform.cfm, accessed August 19, 2008

State of the State January 2008. *Academy Health*, <http://statecoverage.net/pdf/StateofStates2008.pdf>

Incremental Reforms

During 2007, a number of states advanced reform to expand coverage for children, while others focused on parents, the aged and disabled. Listed below are brief descriptions of some of these reforms.

State(s)	Reform Focus	Brief Description
Oklahoma, Ohio, Louisiana	Expand coverage to children	Proposed reforms to expand coverage to children up to 300% FPL was denied by CMS.
Hawaii	Expand coverage to children	Two pilot programs were implemented to expand coverage to infants and children – the Hawaii Infant Health Program provides coverage to uninsured newborns up to 30 days of age for up to \$10,000 in health care assistance per infant.
Connecticut	Expand coverage to Children	The HUSKY program (Medicaid and SCHIP) was expanded to provide coverage for children from 300 to 400%FPL at a cost of \$6 MIL in 2008. Additionally, the state plans automatic enrollment of uninsured newborns in HUSKY and will pay the premium for the first two months; estimated cost - \$2.7 MIL.
Missouri	Expand coverage to children	2007 legislation restores coverage and benefits to some subpopulations whose services were eliminated two years ago including 6,000 children who lost coverage because their parents had access to employer-sponsored health insurance. Additionally, revisions to income eligibility requirements restore SCHIP coverage to about 20,000 children.
New York	Expand coverage to children	Governor Spitzer finalized a budget that would raise the eligibility requirement to the state's Child Health Plus program from 250% to 400% FPL; CMS denied the request.
Texas	Expand coverage to children	Legislation signed by Governor Perry that will: <ul style="list-style-type: none"> • Allow families below 185% FPL to undergo redetermination once rather than twice a year; • Revise a 90-day waiting period requirement so that it applies only to children with health insurance during the 90 days before applying for SCHIP. These revisions may result in the addition of 100,000 children to the SCHIP program. Nearly 25,000 children lost coverage during the first six months of 2007.
Connecticut	Increase Dependent Coverage	Enacted legislation requiring group comprehensive and health insurance policies to extend coverage to children until age 26.
Idaho	Increase Dependent Coverage	Expanded the definition of dependent under a new law; unmarried non-students can remain on their parents' insurance until age 21. Unmarried, financially dependent full-time students can remain on their parents' insurance until age 25.
Indiana	Increase Dependent Coverage	Requires commercial health insurers and HMOs to cover dependents until age 24 at the policy holder's request.
Maine	Increase Dependent Coverage	Passed legislation requiring insurers to continue coverage for dependents until age 25 as long as they remain dependent and do not have dependents of their own.

State(s)	Reform Focus	Brief Description
Maryland	Increase Dependent Coverage	Legislation allows young adults to remain eligible for insurance until age 25 if the individual resides with the insured policyholder and is not married.
Montana	Increase Dependent Coverage	Legislation was passed providing insurance coverage under a parent's policy for unmarried children under age 25.
Washington	Increase Dependent Coverage	Enacted a requirement that any commercial health plan offering insurance coverage must allow the option of covering unmarried dependents until age 25.
Other States	Increase Dependent Coverage	Other states that have increased the age limit for dependents to remain on their parent's policy are: Colorado, Delaware, Massachusetts, New Hampshire, New Jersey, New Mexico, Rhode Island, South Dakota, Texas and Utah.

Source: *State of the State January 2008. Academy Health*, <http://statecoverage.net/pdf/StateofStates2008.pdf>

Additional Strategies

States are increasingly looking at strategies that pair coverage expansions with strategies that incorporate chronic care management and coordination, wellness and prevention, safety, and transparency of data collection through public reporting.⁵ Examples of states proposing or attempting to advance these types of programs are California, West Virginia, Maryland, and Louisiana, among others.

Additional Strategies Specific to Kansas

Other strategies that Kansas implemented or attempted to implement include:

- A Medicaid Transformation Grant – Kansas was awarded a CMS Medicaid Transformation Grant in October of 2006 for \$906,664. The two year grant pilots the use of a predictive modeling tool to identify health needs and improve preventive health care for disabled Kansans enrolled in Medicaid.
- In Kansas a Premium Assistance Program, Kansas Healthy Choices was intended to be an extension of private health insurance to low-income families using a combination of federal, state, and employer funds. The program was authorized by the Legislature and Governor in May 2007 with the signing of Senate Bill 11. Though it was slated for implementation in January of 2009, it was removed from statute by the 2008 legislature. Kansas Healthy Choices was designed to help control state health care spending for the poverty level population by providing broader access to preventive care, and strengthening and expanding the private markets rather than replacing them.
- Community-Based Alternatives to Psychiatric Residential Treatment Facilities (PRTF) – The Department of Social and Rehabilitation Services (SRS), a sister agency to KHPA, was awarded a Community-Based Alternatives to PRTF demonstration grant. The total federal share of the award for the five year demonstration is \$17,406,672. The demonstration will allow the state to use Medicaid funds to provide home and community based services to children and adolescents under the age of 21, as an alternative to PRTF.

Conclusion

Many of the reform efforts summarized here are relatively new or have yet to be fully implemented. The full extent to which these reforms impact health care in their respective states is likely to require further time to evaluate. Exceptions include the Massachusetts program which has demonstrated a significant increase in providing coverage to previously uninsured individuals, and

⁵ Academy Health. *State of the States*, January 2008.

perhaps the preliminary results of Florida's program. Florida launched Medicaid reform pilots in Broward and Duval counties in July 2006 and began enrollment in September 2006. One year later, the pilots were expanded into three more counties. Under the reform, participating plans were allowed to offer different benefit packages, and impose different levels of cost sharing (for nonpregnant adult enrollees), contingent upon state approval. Due to these changes, enrollees were required to compare benefit packages and consider differences such as preferred drug lists, provider networks, and prior authorization requirements when making their choice. Although some of the reform changes have not yet been implemented, reports on the preliminary results have been mixed. Some sources (e.g., the James Madison Institute) point to improvements in access to services and benefit packages, while others (e.g., Georgetown University) indicate a reduction in provider participation and problems associated with beneficiaries not being aware of which plans would cover their medications or doctors.

Aside from the time required to evaluate the impact of state reform efforts, there are other factors that influence the extent to which reform can occur. In the report *The Decline in the Uninsured in 2007: Why Did It Happen and Can It Last?* (Kaiser Commission on Medicaid and the Uninsured, October 2008, <http://www.kff.org/uninsured/7826.cfm>) a number of these factors are cited and include the following:

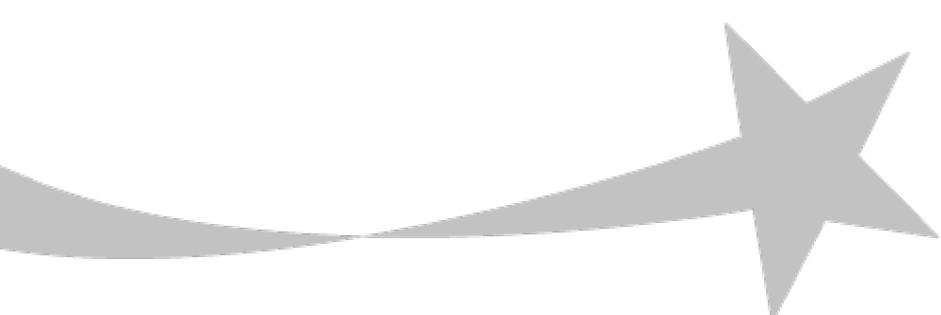
- During an economic decline, states' revenues contract with less funding available for Medicaid and SCHIP budgets.
- At the same time less funding is available, the number of people qualifying for these programs increases.
- During the 2001 to 2004 recession, relief was provided to the states in the form of increased federal matching payment rates.
- To help ensure more people would be covered, the increase in federal funds was contingent upon maintaining existing income eligibility levels.
- During times of economic downturn, states may find it difficult to even maintain their current levels of health coverage let alone address the needs for increased coverage as unemployment increases.

Given our current economic downturn, circumstances such as those described above may have a negative impact on the extent to which states can continue to engage in Medicaid reform. It is possible, however, that a new economic stimulus package being considered at the federal level could include additional funding to state Medicaid programs. If the additional funding is approved, this could help address the collective \$50 billion shortfall the states are facing in fiscal year 2008-2009, and perhaps make cuts on Medicaid and other programs less likely.⁶

⁶ The Henry J. Kaiser Family Foundation. Kaiser Daily Health Policy Report: *Potential Second Economic Stimulus Package Could Include Money for State Medicaid Programs*, <http://www.kff.org/uninsured/7826.cfm>, October 21, 2008.



Kansas Long Term Care Annual Report



January 2009

Kansas Long Term Care

Executive Summary

Long term care is the services and supports individuals need when a chronic illness or disability reduces their ability to care for themselves. Today, long term care is among the costliest of service categories provided by Medicaid. As the nation's demographics change, the demand, and the corresponding cost, is going to continue to grow. Therefore, state programs need to focus on cost effectiveness and serving more people without a resultant escalation in spending.

Nationally, seniors and individuals with disabilities comprise approximately one quarter of Medicaid enrollees, yet account for nearly 70% of Medicaid expenditures. In 2006, 36% of the \$304 billion national Medicaid expenditures were for long term care services.¹

The State of Kansas provides Medicaid long term care services to targeted populations in both community and institutional settings. In the aggregate, community based services are more cost effective than institutional care.

In recent years, much emphasis has been placed on rebalancing the long term care system. The American Association of Retired Persons (AARP) ranked Kansas tenth in the nation for Medicaid long term care expenditures for home and community based services for older adults and individuals with physical disabilities in 2006.²

The State of Kansas operates long term care services through two cabinet level state departments (The Kansas Department of Social and Rehabilitation Services and the Kansas Department on Aging), which operate Medicaid Home and Community Based Service (HCBS) Waivers through a memorandum of understanding with the Kansas Health Policy Authority, the Medicaid Authority for the State of Kansas.

The population to be served often dictates the goals and outcomes of the program and services that are provided. These differing goals drive service design and delivery. The State of Kansas administers four HCBS Waiver programs which provide long term care services. Waiver programs for individuals with physical disabilities, developmental disabilities and traumatic brain injuries are managed by the SRS, while KDOA manages the frail elderly waiver. An overview of each waiver program, including institutional equivalent, eligibility, point of entry, services, average monthly persons served and expenditures is included in this report.

In recent years, the state has been the recipient of several federal grants aimed at long term care reform. In 2005 KDOA was awarded a three year grant from the Administration on Aging and CMS to advance the single point of entry concept through development of Aging and Disability Resource Centers (ADRC) in Kansas. The \$2.2 million Real Choice Systems Transformation grant awarded to SRS in 2006 addresses needed system infrastructure changes, including an emphasis on self-direction opportunities across all HCBS services and gathering valid statistically accurate cost data on which to build reimbursement methodologies.

¹ The Kaiser Foundation. *The Medicaid Program at a Glance*. http://www.kff.org/medicaid/upload/7235_03-2.pdf

² AARP. *Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Kansas and the US, 2006*. http://assets.aarp.org/rgcenter/il/2008_10_ltc_ks.pdf

The Centers for Medicare and Medicaid Services (CMS) awarded a five year “Money Follows the Person” demonstration grant to SRS in 2007. The purpose of the demonstration is to transition consumers out of institutions into the community, allowing their Medicaid funding to pay for community based services. Money Follows the Person is a five-year grant award which concludes in 2011. Kansas’ goal is to transition 963 seniors and individuals with disabilities out of institutions into community based settings.

Implementation of the project began July 1, 2008 and the efforts have already begun to make an impact on the Kansas long term care system. The grant allows the state to provide incentives to facilities to transition from institutional based care to providing home and community based services for individuals with disabilities. As a part of this effort, the last private, large bed Intermediate Care Facility for Mental Retardation (ICF/MR) in Kansas closed its doors in August 2008 and 50 individuals successfully transitioned to community based services.

As Kansas continues efforts to strengthen its long term care system, both to provide the best possible services to older adults and individuals with disabilities and to administer services in the most efficient means possible, quality of life, independence and choice must remain our guiding principles. Continuing challenges to expanded community options include: institutional bias within the Medicaid program, stability in care and staff, lack of adequate program infrastructure and access to health care in the community environment.

Community Based Care

Home and Community Based Services (HCBS) Waivers.

Medicaid waivers are federally approved requests to waive certain specified Medicaid rules. For instance, federal Medicaid rules generally allow states to draw down federal Medicaid funds for services provided in institutions for persons with severe disabilities. Many of the community supports and services provided to persons with disabilities such as respite care, attendant care services, and oral health care are not covered by the regular federal Medicaid program. Home and Community Based Services (HCBS) waivers give the state approval to draw down federal Medicaid matching funds for community supports and services provided to persons who are eligible for institutional placement, but who choose to receive services that allow them to continue to live in the community. CMS requires that the cost of services paid through HCBS waivers be, on the average, less than or equal to the cost of serving people in comparable institutions.

SRS provides long term care through administration of HCBS waivers for individuals with physical disabilities, developmental disabilities, and traumatic brain injury. SRS also provides non-waiver community based services for persons with developmental disabilities. KDOA manages the HCBS frail elderly waiver.

The overview that follows provides information on each of the waiver services as well as developmental disability non-waiver services.

Waiver participation rates and expenditures

Updated 12-11-08

Long Term Care Services	DEVELOPMENTAL DISABILITY WAIVER	PHYSICAL DISABILITY WAIVER	TRAUMATIC BRAIN INJURY WAIVER	FRAIL ELDERLY WAIVER (operated by KS dept. on Aging)
Institutional Equivalent	Intermediate Care Facility for Persons with Mental Retardation	Nursing Facility	Head Injury Rehabilitation Facility	Nursing Facility
Eligibility	<ul style="list-style-type: none"> ➤ Individuals age 5 and up ➤ Meet definition of mental retardation or developmental disability ➤ Eligible for ICF/MR level of care 	<ul style="list-style-type: none"> ➤ Individuals age 16-64* ➤ Determined disabled by SSA ➤ Need assistance with the activities of daily living. ➤ Eligible for nursing facility care <p><i>*Those on the waiver at the time they turn 65 may choose to stay on the waiver</i></p>	<ul style="list-style-type: none"> ➤ Individuals age 16-65 ➤ Have traumatic, non-degenerative brain injury resulting in residual deficits and disabilities ➤ Eligible for in-patient care in a Head Injury Rehabilitation Hospital 	<ul style="list-style-type: none"> ➤ Individuals age 65 or older ➤ Choose HCBS ➤ Functionally eligible for nursing care ➤ No waiver constraints
Point of Entry	Community Developmental Disability Organization	Case management Entities	Case management Entities	Case management Entities
Financial Eligibility Rules	<ul style="list-style-type: none"> ➤ Only the individual's personal income & resources are considered ➤ For individuals under age 18, parent's income & resources are not counted, but are considered for the purpose of determining a family participation fee ➤ Income over \$727 per month must be contributed towards the cost of care 	<ul style="list-style-type: none"> ➤ Only the individual's personal income & resources are considered ➤ For individuals under age 18, parent's income & resources are not counted, but are considered for the purpose of determining a family participation fee ➤ Income over \$727 per month must be contributed towards the cost of care 	<ul style="list-style-type: none"> ➤ Only the individual's personal income & resources are considered ➤ For individuals under age 18, parent's income & resources are not counted, but are considered for the purpose of determining a family participation fee ➤ Income over \$727 per month must be contributed towards the cost of care 	<ul style="list-style-type: none"> ➤ Only the individual's personal income & resources are considered ➤ Income over \$727 per month must be contributed towards the cost of care

	DEVELOPMENTAL DISABILITY WAIVER	PHYSICAL DISABILITY WAIVER	TRAUMATIC BRAIN INJURY WAIVER	FRAIL ELDERLY WAIVER <small>(operated by KS dept. on Aging)</small>
Services/ Supports Additional regular Medicaid services are provided	<ul style="list-style-type: none"> ➤ Assistive Services ➤ Day Services ➤ Medical Alert Rental ➤ Oral Health Services ➤ Sleep Cycle support ➤ Personal Assistant Services ➤ Residential Supports ➤ Supported Employment ➤ Supportive Home Care ➤ Temporary and Overnight Respite ➤ Wellness Monitoring ➤ Family/Individual Supports 	<ul style="list-style-type: none"> ➤ Personal Services ➤ Assistive Services ➤ Sleep Cycle Support ➤ Personal Emergency Response ➤ Personal Emergency Response Installation ➤ Oral Health 	<ul style="list-style-type: none"> ➤ Personal Services ➤ Assistive Services ➤ Rehabilitation Therapies ➤ Transitional Living Skills ➤ Sleep Cycle Support ➤ Personal Emergency Response ➤ Personal Emergency Response Installation ➤ Oral Health 	<ul style="list-style-type: none"> ➤ Adult Day Care ➤ Assistive Technology ➤ Attendant Care Services ➤ Medication Reminder ➤ Nursing Evaluation Visit ➤ Oral Health ➤ Personal Emergency Response ➤ Senior Companion ➤ Sleep Cycle Support ➤ Wellness monitoring
Average Monthly Number Persons Served FY 08	6,822	6,512	196	5,765
FY 08 Expenditures	\$274,843,416	\$109,353,112	\$8,774,567	\$65,780,222
Estimated Average Waiver expenditure Mo/year	\$3,357 / \$40,288	\$1,399/ \$16,793	\$3,731 / \$44,768	\$ 950/ \$11,410
Institutional Setting Cost Per Person per Year	Private ICF/MR \$68,907 Public ICF/MR \$151,332	Nursing Facility \$32,236	Head Injury Rehab Facility \$314,751	Nursing Facility \$32,236

Nursing Facility Care

At the end of SFY 2008, 323 Medicaid certified nursing homes provided 24-hour skilled nursing care. The Medicaid rates are case mix adjusted based on the acuity level of Medicaid residents. Services were provided to an average of 10,581 Medicaid eligible residents each month during the year, a decrease of 0.7% from the previous year. Approximately 92% of all nursing facility residents were over age 65, and about 72% were female. The average age of female nursing home residents was 85, and the average age for male residents was 80. The combined average age was 83.

The total nursing home expenditure in SFY 2008 was \$355.5 million (\$143.4 million state funds) a 3.3% increase from the previous year. The budget is approximately 60% federally funded and 40% state funded.

Long term care initiatives

Aging and Disability Resource Center (ADRC)

The Aging and Disability Resource Center (ADRC) grants create streamlined access to program information, application processes and eligibility determination for all aging and disability services. In Kansas, the ADRC project is collaborating closely with the Real Choice Systems Transformation project as well as other projects that are focused on improving access to community services.

The Kansas ADRC has pilot sites in Wichita (Central Plains Area Agency on Aging and Independent Living Resource Center) and in Hays (Northwest Kansas Area Agency on Aging, Living Independently in Northwest Kansas, and Southeast Kansas Independent Living Resource Center). Staff members from the pilot site agencies are working with staff from KDOA, KHPA and SRS as well as community organizations, service providers and consumers to develop tools that will improve access to services. Work teams are developing a searchable online database of available resources; a referral and assessment process that will speed up referrals between partner agencies; and a web-based interface that will help streamline the Medicaid application process.

ADRC is funded by a combined grant from the Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS). AoA provides 56% of the funding, CMS provides 39%, and the state provides 5%. In the 2007 grant year, AoA provided \$146,125; CMS provided \$103,875; and the state provided \$13,158.

Hospital Discharge Model grant

In 2008, KDOA was awarded a grant from CMS to develop a Person-Centered Hospital Discharge Planning Model to develop hospital discharge models that put patients and caregivers at the center of the discharge planning process; focus on discharging patients home with community-based services; and reduce the number of default discharges to nursing facilities. KDOA will partner with state agencies, Area Agencies on Aging, Centers for Independent Living, local hospital networks and community organizations to

- create a program that elicits patients' input in the discharge planning process;

- develop a comprehensive assessment, information and education program to support caregivers;
- build a strong, collaborative discharge team to support patients' and caregivers' goals; and
- ensure that resources are available to meet patients' discharge goals.

The project will be piloted in three communities that represent the wide range of population demographics in Kansas. We anticipate that our proposed interventions will divert 35% of hospital discharges from nursing home placement to community-based care in our target communities, generating an estimated cost savings of \$5.2 million.

Systems Transformation

CMS awarded a 5 year, \$2.3 million Real Choice System Transformation grant to SRS in 2006. This project seeks to promote community living for Kansans of all ages with long-term support needs by continuing or building upon achievements from previous New Freedom grants awarded to Kansas. The primary goal of the project is to encourage community living options by enhancing consumer control and direction through a coordinated service delivery system.

Specific goals toward achieving this purpose are: enhancement of self-directed service delivery system, transformation of information technology to support systems change and creation of a system that more effectively manages the funding for long-term supports that promote community living options.

A steering committee comprised of consumers, advocates, service providers and state agency staff (SRS, KDOA and KHPA) oversees the work of the project, which is largely comprised of a series of studies designed to assist Kansas in planning for a more effective long term care system. These studies are focused upon:

- Identification of critical elements for individualized planning across long term care services
- Identification of critical elements for individualized budgeting and employer options
- The study and development of appropriate quality assurance systems/tools and data collection instruments across long-term care services
- Study of the Level Of Care documentation, tools, process to make a determination if the current tools utilized are effective in identifying needs of Kansans
- Extensive cost study of the long term care funding systems and payment methodologies

Money Follows the Person

The federally funded Money Follows the Person (MFP) demonstration grant is designed to enhance participating states' ability to increase the capacity of approved HCBS programs to serve individuals that are currently residing in institutional settings. The benefit for Kansas is enhanced federal funding to create additional community capacity, facilitate private ICFs/MR voluntary bed closure, train staff, and ensure individuals have the supports in their homes to be successful, reducing the risk of re-institutionalization.

Target populations for this grant include persons currently residing in nursing facilities and intermediate care facilities for the mentally retarded. Individuals must have resided in the facility for a minimum of six months and have been Medicaid eligible for a minimum of 30 days to be eligible to move into the community.

SRS and KDOA are working together with the LTC Ombudsman office to identify individuals that are currently residing in qualified institutional settings and assist them to move into home settings of their choice. SRS estimates that approximately 963 individuals will make this choice.

SRS, as the lead agency for the demonstration grant, has partnered with the Kansas Department on Aging to develop benchmarks and implementation strategy. Additionally, KHPA is an integral partner as the Single State Medicaid Agency (SSMA).

The required Operational Protocol (implementation strategy) was approved by CMS in April of 2008, and the transition planning process began immediately after receiving the approval. The first actual move dates were July 1, 2008. The individuals transitioning into the community are representing the mentally retarded/developmentally disabled (MR/DD), traumatic brain injury (TBI), physically disabled (PD) and elderly populations groups. Kansans who have chosen community living include 4 persons with physical disabilities, 1 person with a traumatic brain injury and 3 persons that are elderly. Additionally, Kansas has closed 78 private ICFs/MR beds through a voluntary closure process, as a direct result of the MFP demonstration grant project

The MFP movement report, which includes data on numbers of individuals transferred from institutions to community based care and the resultant cost savings to the state is attached as Appendix A. To date, no actual savings have been transferred to the Long Term Care fund.

Challenges to expanded community options

Developmentally Disabled Waiver Waiting List

The MR/DD waiver serves individuals with a developmental disability. At this time there are 1,609 people on the waiting list receiving no waiver services and another 864 people receiving some services who are waiting for additional services. Each year on the average, 208 people come off the waiver and these positions are filled by individuals in crisis situations. SRS maintains one statewide waiting list for HCBS-MR/DD services which includes both the unserved and the underserved. A person's position on the waiting list is determined by the request date for the service(s) for which the person is waiting. Each fiscal year, if funding is made available, people on the statewide waiting list are served, beginning with the oldest request dates at the top of the list. Currently, the persons at the top of the list have been waiting since June 27, 2005.

Physical Disability Waiver Waiting List

On December 1, 2008 SRS implemented a waiting list for the HCBS/PD Waiver. During FY 2008 the rate of growth in the waiver increased significantly. Due to this growth, the program will overspend the appropriated funding. The waiting list was implemented not to cut the budget, but to avoid further overspending. This will allow continuing service provision to the approximately 7,300 individuals currently receiving services. However, no new participants will be added to the HCBS/PD waiver unless they are found to be in crisis, or accessing services through the Money Follows the Person grant.

SRS will monitor the number of requests as well as the crisis situations, and will also work with the Kansas Department on Aging to monitor the number of nursing facility admissions in order to determine if the development of a waiting list increases the number of nursing facility admissions.

Different Funding Methods

The Medicaid system is inherently biased in favor of institutional care because such care is considered a federal entitlement. An individual who is financially eligible for Medicaid and functionally eligible for long term care will receive those services in an institution, unless the institutional requirement is waived. As a result of this bias, Kansas had adopted two distinct funding approaches for long term care.

For institutional services, the budgets for the respective state agencies are achieved through a consensus caseload process. On an annual basis, provider rates are established based on a complex system of reporting health care and operational costs. Inflationary costs of the providers are compensated based on a statutorily required rate setting methodology.

Home and community based services, however, are not considered federal entitlements and yearly funding of these services (provided through the various Medicaid waivers) is subject to recommendation of the Governor and appropriation by the legislature. There is no formal process to accomplish automatic caseload growth and systematic review of provider costs.

Access to Services

Consumer access to long term care services is impacted by the differences in the budget process. In order to provide a true alternative, HCBS services must be available twenty four hours a day in every part of the state. Growth in the community provider network is an essential component of rebalancing the long term care system. Additionally, home and community based services need to be seen by consumers and families as a viable, stable alternative to institutional care.

Limitations on Consumer choice

Individual choice is key to providing effective long term care services. When there are waiting lists for waivers, consumer choice is limited. Not only does the population of individuals receiving long term care services vary in age, disability and need, but also in spending and enrollment patterns and choice of care settings. There is no single model of service delivery that is appropriate to meet the needs of all individuals at all stages of their lives. Long term care policy must take into account individual need and choice to ensure a broad and effective continuum of service options is available; the right options at the right time.

As a person ages, whether the individual has a disability or not, their needs naturally change and the options that work best today may not be the options that best meet the individual's needs five years into the future.

The Kansas long term care system should ensure a broad array of services over the course of a lifetime, appropriate to the individual's age and lifestyle, with flexibility to change service options as needs and circumstances change.

Cost Effectiveness

In the aggregate, community based long term care services are more cost effective than institutional based care:

**Cost Effectiveness of
Home and Community Based Services¹ (HCBS) vs. Institutional Care²
SFY08**

	Institutional Setting	HCBS
Funding	\$434,167,133 (49% of total)	\$ 458,717,795 (51% of total)
Average Number Persons Served	11, 201 (37% of total)	19,295 (63% of total)
Average Cost Per Person	\$38,761	\$23,774

¹ HCBS costs and persons served include waiver services for developmental disability, physical disability, traumatic brain injury and frail elderly

² Institutional costs and persons served reflect services provided in head injury rehabilitation hospitals, Kansas Neurological Institute, Parsons State Hospital and Training Center, private Intermediate Care Facilities for Mental Retardation and nursing facilities.

Long Term Care Services

	FY 2008 Actual		FY 2009 GBR		FY 2010 GBR	
	SGF	AF	SGF	AF	SGF	AF
<u>Institutions</u>						
Nursing Facilities	\$143,244,331	\$355,567,298	\$148,296,000	\$370,000,000	\$144,916,069	\$365,113,329
Intermediate Care Facilities for Mental Retardation	\$6,671,098	\$16,529,934	\$7,433,844	\$18,547,517	\$5,759,267	\$14,510,625
Head Injury Rehabilitation Hospitals	\$3,415,836	\$8,498,292	\$3,164,631	\$7,895,784	\$3,133,836	\$7,895,784
Kansas Neurological Institute	\$13,322,986	\$28,445,708	\$11,112,811	\$28,736,873	\$11,396,168	\$28,385,028
Parsons State Hospital and Training Center	\$10,218,511	\$25,125,901	\$10,614,646	\$25,446,488	\$10,424,288	\$24,794,984
Subtotal Institutions	\$176,872,762	\$434,167,133	\$180,621,932	\$450,626,662	\$175,629,628	\$440,699,750
<u>Waivers</u>						
Physical Disability Waiver	\$44,154,607	\$109,353,112	\$50,430,867	\$125,825,519	\$42,032,126	\$104,870,576
Developmental Disability Waiver	\$109,485,986	\$274,809,894	\$114,469,307	\$289,843,578	\$114,284,890	\$287,943,789
Traumatic Brain Injury Waiver	\$3,542,533	\$8,774,567	\$3,221,037	\$8,036,517	\$3,221,037	\$8,115,485
Frail Elderly Waiver	\$26,246,366	\$65,780,222	\$28,970,590	\$72,281,911	\$28,553,333	\$71,940,874
Subtotal Waivers	\$183,429,492	\$458,717,795	\$197,091,801	\$495,987,525	\$188,091,386	\$472,870,724
Total Long Term Care Services	\$360,302,254	\$892,884,928	\$377,713,733	\$946,614,187	\$363,721,014	\$913,570,474

**KANSAS HEALTH POLICY AUTHORITY
LEGISLATIVE COORDINATING COUNCIL STUDY #7
Waste, Fraud, and Abuse in Medicaid Reform**

Background

On July 9, 2008, the Legislative Coordinating Council, (LCC) approved a number of studies be conducted during the Interim by the Kansas Health Policy Authority (KHPA). Identification of these studies was in response to a May 2008 request made by the Conference Committee on H. Sub. for SB 81. Reporting on which Medicaid anti-fraud/waste/abuse policies have yielded the highest rate of cost benefit was one of the studies identified.

Introduction

Section 6034 of the Deficit Reduction Act of 2005 (DRA) established the Medicaid Integrity Program in section 1936 of the Social Security Act. The Centers for Medicare & Medicaid Services (CMS), Medicaid Integrity Group (MIG) is responsible for implementing the Medicaid Integrity Program. One of the MIG's tasks is to support and assist states in the prevention, detection, and prosecution of Medicaid fraud, waste, and abuse. As one means to do this, the MIG contracted with the Department of Justice to establish the Medicaid Integrity Institute (MII). The MII is located on the campus of the University of South Carolina in Columbia, South Carolina. It focuses on developing a comprehensive program of study addressing aspects of Medicaid program integrity including fraud investigation, data mining and analysis, and case development. MII provides this training at no cost to the states, and KHPA is an active participant. A KHPA staff member was selected to participate on the workgroup tasked to identify states' needs and develop a course curriculum. Four KHPA staff attended the MII in federal fiscal year 2008. Four staff attended in October of 2008, one in December 2008, one in January 2009, and it is anticipated that more will attend as the federal fiscal year progresses.

Best Practice

The MII solicited best practices from each state, the District of Columbia, and Puerto Rico in May of 2008. The responses were distributed to attendees of the Program Integrity Directors Conference in June of 2008. Best practices were also a primary focus of the conference. The following were selected best practices for reducing fraud, waste, and abuse by providers of Medicaid services, followed by KHPA's actions toward implementing the practices. Engaging in best practices, Kansas has saved or avoided \$3,335,469.00 in State Fiscal Year 2008. And, in SFY 2008, the SURS Unit identified \$2,233,319 in overpayments from desk reviews and data mining activities and recouped \$3,730,842. The recouped amount is larger because it includes dollars identified in the current year and in previous years. More than \$5.5 million has been saved or recouped in SFY 2008.

Recommended Practice

1. Cooperative relationships with Program Integrity, Medicaid Fraud Control Units, Offices of Inspector General, United States Attorneys, and active participation in Health Care Fraud Task Forces.

KHPA Medicaid Program Integrity staff, representatives of the Managed Care Organizations (MCO's), and representatives of the fiscal agent meet regularly with the Medicaid Fraud Control Unit (MFCU) of the Kansas Attorney General's office and assists the MFCU and U.S. Attorney's office in case investigation and preparation. KHPA continually works with the MFCU on ways to improve our efforts and on cross-training between all organizations. KHPA representatives attend the quarterly Kansas City Metro

Health Care Fraud Working Group which includes representatives of the FBI, KBI, U.S. Attorney's office, MFCU, private insurance companies, and others from Kansas, Nebraska, Iowa, and Missouri. KHPA staff also participates in CMS sponsored Fraud and Abuse Technical Advisory Group, and Regional Program Integrity conference calls.

2. Update provider agreements to ensure they are consistent with changes in laws and regulations.

In June of 2008, KHPA began the process of renewing provider agreements with all providers enrolled in Medicaid. The new provider agreement updated all references of SRS to KHPA, strengthened the language that incorporated the provider manuals, reflected the transition from paper to electronic claims, and accurately portrayed the language of the record-keeping requirements of the Kansas Medicaid Fraud Control Act. During the same time period, a new Disclosure of Ownership and Control form was implemented. The form was designed to better screen applicants who may be excluded from participation in the program or otherwise sanctioned, and to deter applicants who owe money to the state under one provider number from obtaining a new provider number to avoid payment. To date, no providers have been denied payment due to owing money under another provider number. However, the process acts as a deterrent to those who may have previously been able to evade detection.

3. Pre-payment review monitoring in which new claims are suspended until they have been reviewed by an investigator.

KHPA utilizes pre-payment review in cases where questionable billing practices or poor documentation have been identified. Six providers were on a pre-payment review in fiscal year 2008. Costs avoided due to denied claims by these providers totaled \$6,447.46. This practice has also served as a deterrent to fraud and abuse as all of the providers placed on pre-payment review ceased billing Medicaid once the claims were denied. Based upon the amount these providers were paid in the twelve months prior to being placed on pre-payment review, \$3,089,252 was saved. Three of the providers have since had their provider agreement terminated by KHPA.

4. Use of advanced data analysis and identification of aberrant providers.

KHPA contracts with EDS to conduct post-payment reviews on claims that have already been paid. The program, Surveillance and Utilization Review (SURS), is federally mandated in order to safeguard against unnecessary or inappropriate use of services and against excess payments, and to assess the quality of services. Among other techniques, the SURS unit uses data mining to identify providers who may be billing inappropriately. In FFY 2007, the most recent time period for which this data is available, the SURS Unit identified \$592,604 in overpayments from data mining activities.

5. State review of contractor's audit findings prior to recoupment.

EDS' recoupment letters are thoroughly reviewed for accuracy by State Program Managers and Legal staff prior to being sent to the provider by EDS. This practice avoids correcting errors during the fair hearing process which is a cost saving to both providers and the State.

6. On-site visits before enrollment of certain provider types.

Nationally, states, including Kansas have identified ongoing problems with providers of Durable Medical Equipment (DME). As a result of past problems, Provider Representatives from EDS now conduct site visits on all Durable Medical Equipment

providers prior to enrollment. Providers who do not meet program requirements are not enrolled. KHPA denied enrollment of three DME providers in SFY 2008 for not meeting program requirements. Based upon the average yearly amount paid to this provider type, this resulted in costs saving in the amount of \$50,713.

7. Review of selected provider enrollment applications to prevent questionable providers from enrolling in the program.

The KHPA Program Manager for Transportation Services reviews and verifies all applications for transportation providers prior to enrollment. Issues related to overpayment of providers, and enrollments of non-qualified providers were identified as ongoing problems in this Medicaid program. KHPA denied the enrollment of nine transportation providers in SFY 08. Based upon the average yearly amount paid to this provider type, this resulted in cost saving in the amount of \$195,504. Adjustments have also been made to the provider enrollment application which limits the ability of providers to re-enroll as a new provider without reimbursing the state for prior overpayments.

8. Legislation to form a computerized central database tracking system to track prescribing, dispensing and consumption of schedule II, III and IV controlled substances.

SB 491 requires the Board of Pharmacy to create a Prescription Monitoring Program (PMP) for Kansas and created a PMP Advisory Committee to develop and oversee the program. KHPA has a staff member on the committee.

9. Notification to various Boards (Healing Arts, Pharmacy, Nursing) when patterns of inappropriate activities are identified

KHPA and EDS staff routinely notify the appropriate Board when patterns of inappropriate activities are identified. Notices to Boards generally pertain to quality of care concerns and are based upon the Board's standards. Seven providers were referred to the State licensing boards in FFY 2007.

10. Conduct on-site visits to review provider records, meet with providers, and observe some of the services being provided.

The SURS unit has the authority to conduct on-site visits as necessary. However, SURS staff has found other options that are more productive, less costly and time consuming to review services, and exercise those options. For example, focused reviews are conducted. Focused reviews identify a single, questionable practice exhibited over multiple providers, occurring frequently enough to be investigated. Desk reviews are also conducted. In this instance, provider records are sent to KHPA for staff to review and compare with information contained in the MMIS. Desk reviews are more efficient as they do not require staff to go off-site, and, because they are conducted in office, staff may access MMIS records which would not occur in an on-site visit.

11. Time-line analysis of provider billings

In addition to a time-line analysis of Medicaid provider billings, this analysis is being explored in conjunction with the State Employee Health Insurance Program and the Kansas Insurance Commission data bases through the Data Analytic Interface. This option will allow KHPA to compare providers across all three groups to determine total number of hours billed per day or other specified time period by providers.

12. Receive referrals alleging fraud or abuse via Recipient Explanation of Medicaid Benefits (REOMB).

KHPA is currently in the process of improving the REOMBs to target specific provider types or beneficiary populations to reach populations more vulnerable to fraud and abuse without raising the cost. The current process selects beneficiaries randomly from all populations. One state reported initiating from two to four investigations per month from targeting REOMBs.

13. Use of a standardized form for referrals of suspected fraud to the MFCU.

MFCU and KHPA are currently working on a standardized form and process to refer all cases of suspected fraud to the MFCU. The form and the standardized information it will contain will be used by KHPA, SRS, KDOA, MCOs, and any other agency or contractor to make a referral to the MFCU. The form will also meet the Best Practices identified by CMS for Medicaid fraud referrals.

Future Practice

The following are best practices that KHPA does not currently have in place but are exploring for possible future use:

- **Random Pre-Pay Reviews:** This process is an anti-fraud control strategy that puts providers on notice that all claims submitted for payment is at risk for review prior to payment. A pre-determined number of claims would be selected for review on a weekly basis. Providers would be required to submit documentation to support the payment before the claim is approved. Any claim that cannot be supported is denied for payment.
- **Provider Self Audits:** This is a review of providers for deficiencies in their billing and request that the providers audit their own records. Providers repay the state if they identify an overpayment. One state claimed to have had over \$2 million in collections in Federal Fiscal Year 2007 from this process.

Although the MII's focus is currently on preventing, detecting, and prosecuting provider fraud, waste, and abuse, some states offered their best practices in the area of beneficiary fraud and abuse. All involved a program in which beneficiaries are limited to one physician, pharmacy, or hospital when patterns of abuse are identified. KHPA and the MCOs also employ this program, entitled Lock-In, to control the costs associated with beneficiaries' abuse of Medicaid benefits.

None of the states offered any best practices regarding beneficiary eligibility fraud at the MII. KHPA has discussed pursuing beneficiary fraud with the Medicaid Fraud and Control Unit in the Attorney General's office. More resources would be required to implement a beneficiary fraud program, and it does not appear that this is a widespread problem in the Kansas Medicaid Program.

**KANSAS HEALTH POLICY AUTHORITY
LEGISLATIVE COORDINATING COUNCIL STUDY #8
Health Opportunity Accounts (HOAs)**

Background

The Health Savings Account

In recent years, consumer-directed health care has increasingly been used as a means to encourage people to make informed, cost-effective decisions about their health care.¹ One of the primary strategies used within the consumer-directed health care approach is to offer Health Savings Accounts (HSAs). The HSA was authorized through federal legislation in 2003 and is a type of medical savings account that allows consumers to save for medical expenses on a tax-free basis. Both individuals and employers can contribute to the HSA; the contributions are tax-deductible if made by the consumer and tax-exempt if made by the employer. In order to establish an HSA, the consumer must be enrolled in a high deductible health plan (HDHP). Typically, HDHPs are characterized by greater out-of-pocket spending, lower premiums, and higher deductibles. Advantages of establishing an HSA include providing the consumer with a mechanism to save for their health care costs, ownership of the account, rollover of unused funds from one year to the next, and portability (i.e., the consumer may keep their account if they switch jobs or are no longer enrolled in an HSA-eligible plan). Because consumers must pay for most of the medical costs out-of-pocket until they reach the plan's deductible, however, they face increased financial risks. One of the premises behind the HSA is that consumers will be financially motivated to contain their health care costs in light of the financial responsibility they assume.

Basic Features of the HSA

- A savings account that allows the owner to save for medical expenses on a tax free basis.
- In order to establish an HSA, the consumer must choose a high deductible insurance plan; the deductible being the dollar amount at which the insurer begins to cover some or all of the medical bills.
- Funds in the HSA are to be used to pay for the consumer's share of health care costs and generally cannot be used towards the cost of premiums.
- After the deductible is met, health insurance plans typically require additional cost-sharing in the form of co-payments and co-insurance.

Source: Kaiser Commission on Medicaid and the Uninsured
www.kff.org/uninsured/7568.cfm

The Health Opportunity Account

While consumer-directed health care approaches were first introduced into the commercial and Medicare markets, state Medicaid agencies have also begun testing these strategies.² Health Opportunity Accounts (HOAs) are among the strategies being explored. HOAs were established as part of the Deficit Reduction Act of 2005 (DRA). Like the HSA, HOAs function as a type of medical savings account and are linked to a high deductible version of Medicaid. Unlike the HSA, however, contributions to the account are made using state funds and federal matching dollars, and may also include contributions from charitable organizations.

The HOA provision established in the DRA became effective on January 1, 2007, and allowed the Centers for Medicare and Medicaid Services (CMS) to approve demonstration projects in up to 10 states. The purpose of the demonstration projects is to determine if HOAs, in combination with high deductible insurance plans, are an efficient way to deliver health care benefits to Medicaid beneficiaries. The Medicaid HOAs incorporate key components of HSAs into the Medicaid demonstration program.

Elements of the HOA demonstration programs include:

¹ Greene, Jessica, *State Approaches to Consumer Direction in Medicaid*. Center for Health Care Strategies, Inc. July 2007.

² *Ibid.*

- Participants must have both an HOA and coverage for medical items and services that are available under the existing Medicaid state plan or Section 1115 waiver authority, after an annual deductible is met.
- The HOA requires the consumer to pay for health care expenses out of the account and then out-of-pocket until the deductible is met.
- Contributions may be made by the state (not to exceed \$2,500/adult and \$1,000/child including federal match) or others (including charitable organizations).
- Deductibles may not apply to preventive care.

Certain eligibility components are outlined in the DRA, including:

- Eligibility is determined by the state although people who are aged, disabled, pregnant, or receiving terminal or long-term care are ineligible.
- Individuals may continue to make withdrawals from their HOA, under state-specified conditions, for up to three years after Medicaid eligibility termination (no additional account contributions will be made thereafter and balances will be reduced by 25%).
- For individuals who participate in a demonstration for at least one year and later become ineligible, funds from the account can be used for health insurance, job training, or educational expenses.

Source: Joint Commission on Health Care

HSA Implementation

Because the HOA is very similar in design to the HSA, and the HSA was established and implemented prior to the HOA, reviewing outcomes and issues associated with HSA implementation is helpful. As reported in a 2006 issue brief published by the Kaiser Commission in October 2006, “high deductible health plans that meet the HSA requirements are still relatively rare.”³ The statistics presented in a 2008 General Accountability Office (GAO) report support this observation. Findings in the GAO report are based upon industry and Internal Revenue Service (IRS) data and include the following:

- Between September 2004 and January 2007, the number of individuals covered by HSA-eligible plans increased significantly, from about 438,000 to approximately 4.5 million. Despite this growth:
 - Many of the HSA eligible plan enrollees (42 percent to 49 percent) reported they had not opened an HSA (findings were obtained from nationally representative surveys conducted in 2005, 2006, and 2007), and
 - Only a small share of individuals with private health care coverage was represented by these plans (approximately 2 percent in 2006).
- Additionally, tax filers who reported HSA activity in 2005 had higher incomes on average than other tax filers; among the tax filers between the ages of 19 and 64, the average adjusted gross income was approximately \$139,000 compared with about \$57,000 for all other filers. These income differences were observed across all age groups.

Source: GAO-080474R Health Savings Accounts

Other key findings that were reported in the Kaiser 2006 issue brief included:

- The lower premiums associated with HSA-qualified health plans are lower in part because they shift more of the financial risk to individuals and families through higher deductibles;
- Premiums and out-of-pocket costs for HSA-qualified health plans will consume a substantial portion of a low-income family’s budget;

³ Kaiser Commission on Medicaid and the Uninsured. “Health Savings Accounts and High Deductible Health Plans: Are They An Option for Low-Income Families?” October 2006. <http://www.kff.org/uninsured/7568.cfm>

- Most low-income individuals and families do not experience a high enough tax liability to benefit in a significant way from the tax deductions associated with HSAs (e.g., according to data from the U.S. Department of Treasury, a family of four with an income of \$20,000 would receive no benefit from contributing any amount to an HSA);
- People with chronic conditions, disabilities, and others with high-cost medical needs may face even greater out-of-pocket costs under HSA-qualified health plans (i.e., these individuals are much more likely to reach their deductible level each year, which is set at a much higher level in the HDHP);
- Research from the RAND Health Insurance Experiment found that people enrolled in cost-sharing health plans were significantly less likely to see a doctor for services (including general health, vision exams, and treatment for infections) than people enrolled in health plans with no cost-sharing (the gap was greater for those with low incomes - <200 percent of the poverty level); and
- HSAs and HDHPs are unlikely to substantially increase health insurance coverage among the uninsured:
 - Over two-thirds of the nonelderly uninsured are low income; because they earn so little over half have no tax liability;
 - As such, offering plans that offer tax deductions as an incentive will have limited impact on the number of uninsured; and
 - The out-of-pocket spending that is required will not offer the low-income uninsured enough financial protection to offset the premium cost.

Source: *Health Savings Accounts and High Deductible Health Plans: Are They an Option for Low-Income Families?*. Kaiser Commission on Medicaid and the Uninsured, October 2006.

HOA Implementation

Currently, two states offer an HOA to their Medicaid population. Below is a summary of each state's HOA program.

Indiana

Implementation Date	December 2007
Program Type	1115(a) Demonstration Waiver
Incentives	\$500 in "first dollar" preventive benefits at no cost to members
Geographic Areas	Statewide
Eligibility	Adults meeting specific eligibility criteria
Benefits	Basic commercial insurance package provided by contracting insurance companies
Deductible	Up to 5% (\$1,100) of gross family income
State Contribution	Gap between designated deductible and \$1,100
Enrollment	Approximately 28,000

South Carolina

Implementation Date	December 2007
Program Type	State Plan Amendment
Incentives	Preventive care and appropriate ER services are not applied toward the deductible
Geographic Areas	Richland County
Eligibility	Adults and children that have been eligible for three months
Benefits	Traditional Fee-For-Service benefit package
Out of Pocket Expenses	\$250 per adult, \$100 per child if State Contribution is exhausted

(Deductible)	
State Contribution	\$2,500 per adult, \$1,000 per child
Enrollment	5

With respect to Indiana's plan (the Healthy Indiana Plan or HIP), it is helpful to note some of its more significant features. The HIP plan is:

- Open to any Indiana resident ages 19 to 64 who:
 - Earns less than 200 percent of the FPL;
 - Has been uninsured for at least six months;
 - Is a U.S. citizen;
 - Does not have access to employer-sponsored health insurance; and
 - Is not eligible for Medicaid or Medicare.
- Indiana's existing Medicaid program, Hoosier Healthwise, restricts income eligibility for non-disabled adults to no more than 22 percent of the FPL – nearly the lowest coverage limit in the U.S.
- The HIP is intended to fill the gap in coverage between Medicaid and private insurance.

Source: *States in Action: A Bimonthly Look at Innovations in Health Policy*. The Commonwealth Fund Organization, February/March 2008.

Internal Analysis of the HOA

Little state-specific information regarding HOA use for the Medicaid population is available. Available resources are most often regarding the availability of the alternative benefit package through the Deficit Reduction Act only. No articles evaluating the success of the HOAs used within state medical assistance programs were located.

The Healthy Indiana Program is very comprehensive and, by enrollment terms, appears to be successful. Indiana contracts with private insurance companies to provide medical services and opens a Personal Wellness and Responsibility (POWER) account where family and/or state contributions are deposited for use. They also complement the program by offering an Enhanced Service Plan to screen and enroll beneficiaries with high risk conditions into the State's high-risk pool.

Resources with the state report South Carolina's Health Opportunity Account enrollment has been very slow. Per the State Plan Amendment, enrollment is capped at 1,000. Although the application process began December 2007, the state just recently enrolled beneficiaries into the program and has not yet processed claims. To date, enrollment includes one family of four (adults, children) and one child. Marketing efforts have included two mailings and county-wide distribution of flyers regarding the program. A third mailing is being planned. State officials attribute the low enrollment to the recent transitioning of the Medicaid population to managed care and the beneficiaries' being less inclined to try this new option.

National Analysis of the HOA

There are few articles or summaries regarding Medicaid enrollment in Health Opportunity Accounts. The most recent are dated 2006. High deductible health plans are relatively new to the insurance industry; therefore, only summations can be made about their impact on the Medicaid population. The following are conclusions drawn from the most recent literature found on the subject.

“By encouraging individuals and families to choose high deductible health plans and set up HSAs, it is assumed that consumers will eventually become more cost-conscious, enabling them to make more cost-effective decisions about their health and health care. However, most low-income individuals and families are already making these tougher cost-benefit decisions as each health need arises. And the research to date shows that unaffordable cost-sharing among the low-income population not only decreases access to needed care but, in some circumstances, can also lead to

poorer health. For low-income families in particular, HSAs and HDHPs may exacerbate, rather than alleviate, the problems they currently face in affording and accessing needed health care.”⁴

“The Health Opportunity Accounts could leave some beneficiaries, particularly those in poorer health, responsible for out-of-pocket costs related to health services they need when they have exhausted their accounts but not yet met the deductible. These costs would be on top of the standard copayments that beneficiaries would have to pay once the deductible was exhausted, which themselves would be increased by other Medicaid provisions of the Energy and Commerce reconciliation package. Research indicates that increased cost-sharing particularly affects the ability of low-income individuals to access health care.

At the same time, the Health Opportunity Accounts would add to federal Medicaid costs. By allowing former beneficiaries to keep balances held in their accounts, the federal government would essentially be paying for benefits provided to individuals and families no longer eligible for Medicaid. The demonstration project also would permit, at state option, the use of federal Medicaid dollars to pay for health care services not covered under Medicaid and even for non-medical services.”⁵

“Factors other than patient cost-sharing also will impact the development of consumerism in the Medicaid program. Compared to the general population, Medicaid beneficiaries have lower levels of health literacy, less familiarity navigating the health care delivery system, and less experience and support researching and evaluating medical options.”

Conclusion

In addition to the local and national analyses on HOAs described above, during September, 2007, the Kansas Health Institute developed a summary of main issues for states to consider when implementing consumer directed health purchasing (CDHP). Listed below are some of the issues and considerations that were identified.

Savings

Within the context of Medicaid reform, there are some reasons to believe that cost-savings may not be as great as in the private sector. Since beneficiaries will be paying for the up-front deductible costs with Medicaid funds, instead of their own money, the financial incentives may not be as great. Furthermore, they may be motivated to spend larger portions of the deductible amount if the incentives for saving are not present (e.g., availability of funds after leaving the Medicaid program; federally required reductions in the account balance upon leaving the program, etc.).

Conversely, if Medicaid recipients are allowed to keep the unexpended funds in their HOAs for up to three years, even if discounted 25 percent (as specified in the DRA), and are able to use the money on future health care expenses, education costs, or job training, they may experience incentives that encourage cost-conscious health care spending.

Eligibility

If Kansas incorporated CDHP into the Medicaid program, most participants would be healthy children and adults as required by the DRA. Although these individuals make up a substantial

⁴ Catherine Hoffman and Jennifer Tolbert, Health Savings Accounts and High Deductible Health Plans: Are They An Option for Low-Income Families? (The Kaiser Commission on Medicaid and the Underinsured , October 2006)

⁵ Edwin Park and Judith Soloman, Health Opportunity Accounts for Low-Income Medicaid Beneficiaries: A Risky Approach (Center on Budget and Policy Priorities, November 2005)

percentage of Medicaid beneficiaries, they are responsible for a much smaller portion of Medicaid costs. Most of the Medicaid expenditures come from coverage of other populations which would be excluded from participating in HOAs (e.g., the aged and disabled). Therefore, the net impact on Medicaid spending may be less than expected.

Administrative Costs

Administrative costs associated with implementation of CDHP would need to be considered within the context of the overall fiscal impact of the program. For example, the DRA requires states that implement HOAs to develop and electronic monitoring and funds transfer system for the use of monies in the accounts (i.e., cash is not involved).

Other

Within the context of CDHP, and given the demographics of Medicaid enrollees, experts recommend a heavy emphasis on education, outreach, and quality initiatives to help beneficiaries distinguish between necessary and unnecessary care. Many of the state plans that are emerging include the availability of health counselors to assist in the selection of health plans to better understand available services and incentives.

Source: Memo on Consumer Directed Health Purchasing in Medicaid. The Kansas Health Institute, September 2007.

**KANSAS HEALTH POLICY AUTHORITY
LEGISLATIVE COORDINATING COUNCIL STUDY #9
Medicaid Reforms Allowed by Federal Law
Deficit Reduction Act of 2005¹**

Background

On July 9, 2008, the Legislative Coordinating Council (LCC) approved a number of studies to be conducted during the Interim by the Kansas Health Policy Authority (KHPA). Identification of these studies was in response to a May 2008 request made by the Conference Committee on H. Sub. For SB 81. Reporting on the flexibility in Medicaid design allowed under federal law was one of the studies identified.

Introduction

The Deficit Reduction Act of 2005 (DRA) is the result of a budget resolution passed in 2005. The resolution called for several committees in Congress to recommend legislation that would reduce federal spending by \$35 billion from 2006 – 2010. CBO estimates are that the DRA will reduce federal spending by \$39 billion over five years. About one third of that amount will come from changes in Medicare or Medicaid programs. Listed below are brief summaries of the key components of the DRA.

Federal Upper Payment Limit for Multiple Source Drugs

The federal upper payment limit (FUL) which applies to multiple source drugs for which the Food and Drug Administration has rated two or more products to be therapeutically and pharmaceutically equivalent, will be calculated as equal to 250% of the average manufacturer wholesalers. CMS previously calculated the FUL to be equal to 150% of the published price for the least costly therapeutic equivalent.

Reform of Asset Transfer Rules

Assets transferred for less than fair market value during the “look-back period” before an individual applies for Medicaid are added to the applicant’s countable resources. The individual’s eligibility for Medicaid for long-term care will be delayed for a penalty period; the length of the penalty period is calculated by dividing the uncompensated value of the transferred assets by the monthly cost of private nursing care in the state. The look-back period for most transfers is mandatory and was increased from 36 months to 60 months.

Expansion of State Long-Term Care Partnership Program

The state long-term care partnership consists of two elements: (1) provisions in the state Medicaid plan to disregard assets to the extent of payments made under a long-term care policy; and (2) insurance policies meeting certain requirements. The policy must:

- be a qualified long-term care insurance policy as defined by Internal Revenue Code
- have been issued on or after the effective date of the state plan amendment
- cover an insured who was a resident of the state when coverage became effective
- meet the model regulations and requirements of the model Act

¹ Deficit Reduction Act of 2005, Public Law 109-107, CCH Law and Explanation, Wolters Kluwer

- contain inflation protections based on the age at which the beneficiary purchased the policy.

A certificate under a group insurance contract may be a long-term care insurance policy. If the insured has exchanged one policy for another, the requirement of the state residence applies to the first policy issued. If, when the policy is sold, the insured is under the age of 61, it must provide compound annual inflation protection. If the purchaser is between 61 and 76 years old, it must have some level of inflation protection. If the purchaser is 76 years or older, inflation protection is optional. The Medicaid agency must assist the state department of insurance to assure that the individuals who sell long-term care partnership policies are trained and demonstrate an understanding of the policies and their relationship to other public and private coverage of long-term care.

The policies must meet the requirements of the Long-Term Care Insurance Model Act and Long-Term Care Model Insurance Regulations published by the National Association of Insurance Commissioners for consumer protection. The policies must be portable; therefore, by January 1, 2007, the Secretary must develop standards for uniform reciprocal recognition of long-term care partnership policies among the states with qualified partnerships so that benefits paid under the policies will be treated the same way by all states. Kansas implemented a Long-Term Care Partnership Program in April 2007.

Eliminating Fraud, Waste and Abuse in Medicaid

Beginning January 2007, the Federal Medical Assistance Percentage (FMAP) for amounts recovered under state false claims actions will be decreased by 10 percentage points to encourage states to establish and maintain laws and standards for the prosecution of false or fraudulent Medicaid claims. Generally, states must repay the federal share of any provider overpayment within 60 days of discovering the overpayment whether or not the state has recovered the overpayment. The amount of repayment is determined by the FMAP. The provision established a reduction in the FMAP for those states whose false claims legislation meets the requirements of the Inspector General of HHS (OIG). Kansas implemented a policy to ensure these federal requirements are met.

Flexibility in Cost Sharing and Benefits

States, through Medicaid state plan amendments, may impose premiums and cost sharing for any group of individuals for any type of services, except for prescribed drugs which are treated separately, and may vary such premiums and cost sharing among such groups of individuals or types of service. The existing Social Security Administration (SSA) provisions on premiums and cost sharing for workers with disabilities are not affected by the amendment. The income eligibility limits for Medicaid are extremely low in Kansas. Cost sharing for this very low income population is formidable. See Legislative Coordinating Council Study 4 for a review of potential cost sharing and buy in options for Medicaid eligible families.

Special Rules for Cost Sharing for Prescription Drugs

States may impose higher cost sharing amounts for state-identified non-preferred drugs within a class, and waive or reduce the cost sharing otherwise applicable for preferred drugs within a class of drugs. States may not apply such cost sharing otherwise applicable for preferred drugs for individuals exempt from cost sharing. Preferred drugs are those identified by the state as the least costly effective prescription within a class of drugs. In Kansas, the standard

prescription co-payment for Medicaid beneficiaries is \$3.00 regardless of class of drug, or whether it is a brand name or generic drug.

Emergency Room Copayments for Non-Emergency Care

State plans may be amended to permit a hospital to impose cost sharing on individuals, within state-specified groups, for non-emergency services furnished to an individual in the hospital emergency department, if certain criteria are met. Kansas does not impose a co-pay in this instance.

Use of Benchmark Benefit Packages

A state has the option to amend its state plan to provide for Medicaid assistance to state-specified groups through enrollment in: (1) benchmark or benchmark equivalent coverage, and (2) wrap-around benefits to the benchmark coverage or benchmark equivalent coverage, consisting of early and periodic screening, diagnostic, and treatment services, for any child under the age of 19 under a state plan. Kansas proposed the use of benchmark plans by establishing a Premium Assistance program, Healthy Choices, which was repealed.

Reforms of State Financing Under Medicaid

Managed Care Organization Provider Tax Reform

Medicaid managed care organization (MCO) provider classes will expand to include all MCO's, which includes both Medicaid and non-Medicaid MCO's. States desiring to qualify for federal reimbursement should apply to both MCO's. KHPA has analyzed this approach and does not propose to pursue it at this time.

Reforms of Case Management and Targeted Case Management

The definitions of case management and targeted case management services have been modified. Case management services are defined as those services that will assist Medicaid-eligible individuals in gaining access to needed medical, social, educational, and other services. Such services include:

- Assessment of an eligible individual to determine needed services
- Development of a specific plan of care based on information collected
- Referrals and related activated to help an individual obtain needed services
- Monitoring to ensure that an individual's care plan is effectively implemented and adequately addresses the individual's need

Activities that are not reimbursable as case management services include the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual is referred. Kansas meets federal regulation through CMS approval of its State Plan Amendment in December, 2007.

Miscellaneous Medicaid Provisions

Family Opportunity Act

A new optional Medicaid eligibility group has been created for children with disabilities under the age of 19 who meet the severity of disability requirement under the Supplemental Security Income (SSI) program, without regard to any income or asset eligibility requirements applicable under SSI for children, and whose family income does not exceed 300% of the federal poverty level (FPL).

Demonstration Projects Regarding Home and Community Based Alternatives to Psychiatric Residential Treatment Facilities for Children

The Secretary is authorized to award grants on a competitive basis to conduct demonstration projects in up to 10 states during fiscal years 2007-2011. The project will test the effectiveness of improving or maintaining a child's functional level and the cost-effectiveness of providing coverage for alternative home and community based services (HCBS) to psychiatric residential treatment (PRTF) for children enrolled in Medicaid.

Money Follows the Person Rebalancing Demonstration

To increase state use of home and community based care, the Secretary of HHS will award grants to states to conduct demonstration projects that will (1) expand the state's capacity to provide home and community based long term care services for individuals who choose to transition into the community, and (2) ensure that procedures are in place to provide quality assurance and continuous quality improvement that is comparable to other Medicaid home and community based services. The project will also help relocate individuals from institutions into the community. Kansas was awarded a Money Follows the Person (MFP) demonstration grant in May 2007, in the amount of \$37 million over 5 years.

Medicaid Transformation Grants

The Secretary will provide for payments to states for the adoption of innovative methods to improve the effectiveness and efficiency of providing medical assistance for a two year period beginning in FFY 2007. Kansas was awarded a CMS Medicaid Transformation Grant in October of 2006 for \$906,664.

Health Opportunity Accounts

The Secretary is required to establish no more than 10 demonstration programs with Medicaid for health opportunity accounts (HOAs). After a five year initial period, if the programs are determined to be successful based on quality of care and cost effectiveness, the program may be extended or made permanent in the state and other states may implement the demonstration programs. The Kansas Healthy Choices program, a Premium Assistance model was proposed by KHPA, and repealed. It included a pilot on consumer driven health care including Health Opportunity Accounts (HOA's) which allow incentives to be provided to beneficiaries seeking preventive care services.

State Option to Establish Non-Emergency Medical Transportation Program

A state may establish a non-emergency medical transportation brokerage program for beneficiaries who need access to medical care and have no other means of transportation. The program may include a wheelchair van, taxi, stretcher car, bus tickets and any other transportation that the Secretary finds appropriate. KHPA proposes to establish a transportation brokerage program.

Home and Community-Based Services as an Optional Benefit for Elderly and Disabled Beneficiaries

States may provide medical assistance for home-and community-based services in their state plan amendments. The services would be for beneficiaries whose income does not exceed 150% of the FPL who are eligible for medical assistance under the state plan. The state may provide this option with determining that, but for the provision of such services, the beneficiaries would require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICFMR).

Optional Choice of Self-Directed Personal Assistance Services

A state may cover payment for part or all of the cost of self-directed personal assistance activities based on a written plan of care to individuals for whom there had been a determination that, but for the provisions of such services, the individuals would require and receive personal care services under the plan or home – and community – based services provided pursuant to a waiver under the SSA. Self-directed personal assistance services may not be provided to beneficiaries who reside in a home or property that is owned or operated by a provider not related by blood marriage. Kansas offers self directed Personal Assistance Services through the Demonstration to Maintain Independence and Employment grant.

Notice of Proposed Rulemaking under Moratorium

In an attempt to address what it perceived as violations in Medicaid policy, the Bush administration cited Government Accountability Office (GAO) and Office of Inspector General (OIG) reports to justify the formulation new of regulations that would restrict payment for certain Medicaid expenses. In response to the newly released CMS notice of proposed regulations, Sen. Henry Waxman surveyed all State Medicaid Directors to assess the impact of the proposed rules. In March, 2008, KHPA wrote to the Kansas Congressional delegation citing the regulations as potentially onerous, fiscally and programmatically burdensome. In June, 2008 the Iraq War Funding bill was signed which included suspension of the six regulatory actions proposed by CMS. These six proposed rules have direct impact on the Medicaid program and are under Moratorium until April 1, 2009. The impact to Kansas reflects the fiscal impact for one year.

1. **Public Provider Reimbursement**
A change in the definition of a unit of government which limits the types of entities authorized to provide non-federal share funding, and determines which health care providers would be subject to the new cost limit. Governmental hospitals would be negatively impacted due to change in cost based UPL calculation. Courts ruled the regulation was not legally adopted, it could be republished by CMS after April 1, 2009.
Impact to KS: \$18.7 M
2. **Graduate Medical Education Payments**
Costs and payments associated with direct GME programs are not eligible for FFP under state Medicaid programs. CMS contends the current methodology does not provide for clear accountability, payments are difficult to track, and there is little assurance they are supporting GME programs that benefit Medicaid beneficiaries. CMS never adopted this proposed rule issued on May 23, 2007; no action may be taken before April 1, 2009
Impact to KS: \$1.178 M
3. **Rehabilitation Services**
CMS is prohibiting payment for services through the Medicaid rehabilitation option if such services could be funded through other federal, state or local programs. Prohibits imposition of any restrictions relating to the coverage of or payment for these services that were more restrictive than those in place as of July 1, 2007.
Impact to KS: Undetermined
4. **School Based Administration and Transportation Services**
CMS published a final rule on Dec. 28, 2007 which eliminated payment for school based administration and severely curtailed payment for school based transportation. Sec 206 of PL 110-173 postponed the effective date to June 30, 2008, the War Funding bill extends the date to April 1, 2009
Impact to KS: \$3.3M

5. Targeted Case Management
The funding bill suspends CMS' interim final rule, published Dec. 4, 2007 until April 1, 2009, except for the portion that adopts the DRA definitions of case management services and targeted case management services, only to the extent those definitions are not more restrictive than the policies set forth in a State Medicaid Director (SMD) letter on Jan 19, 2001 or the SMD letter of July 25, 2000.
Impact to KS: Undetermined
6. Provider Taxes
Suspends until April 1, 2009 the effect of the final rule on provider taxes published on Feb. 22, 2008, except the portions that implement the Congressionally-mandated change in the hold harmless safe harbor percentage from 6 percent to 5.5 percent (until Sept. 30, 2011) and a new definition of the Medicaid managed care service class of providers that can be taxed.
Impact to KS: Undetermined

Other Flexibilities

States may use the DRA in combination with other options under titles XIX and XXI of the Social Security Act, and other programs to create meaningful reform in their state. The table below lists waiver options along with state plan options available under Federal law that offer flexibility to help states manage their Medicaid programs.

1915(c) Waivers	Home and Community Based Services waivers. This section of the law allows the Secretary of HHS to waive Medicaid provisions in order to allow long term care services to be delivered in community settings. This program is the Medicaid alternative to providing comprehensive long term services in institutional setting.
1915 (b) Waivers	Managed Care/Freedom of Choice waivers. This section allows the Secretary to grant waivers that allows states to implement managed care delivery systems, or otherwise limit individual's choice of provider under Medicaid.
1115 Research and Demonstration Projects	This section provides the Secretary of HHS broad authority to approve state projects that test policy innovations likely to further the objectives of the Medicaid program
Combined 1915(b)/(c) Waivers	States use 1915(b) to limit freedom of choice and 1915(c) to target eligibility for the program and provide HCBS. This option allows states to provide long term care services in a managed care environment.
1115 Demonstration HIFA Waivers	The HIFA option under 1115 is specifically designed to help states extend coverage to uninsured individuals.
1915(i) Waiver	States have the option to amend their State plans to provide Home and Community Based services without regard to statewideness or certain other Medicaid requirements, and may establish needs based criteria for eligibility. These services may include case management, homemaker/home health aide, personal care services, adult day health services, habilitation services and respite care.
1915(i)(1)	This section of the Act gives states the option of providing HCBS under their state plan to individuals eligible for Medicaid under an eligibility group covered in the state plan, and who have income that does not exceed 150% of the FPL.
1915 (i)(3) HCBS Program	Under this section of the Act, States may exercise the option not to

Eligibility	apply 1902(a) (10) of the Act which pertains to income and resource eligibility rules for the medically needy living in the community. This election allows States to treat medically needy individuals as if they are living in an institution by not deeming income and resources from an ineligible spouse to an applicant, or from a parent or child.
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Source: Centers for Medicare and Medicaid Services, www.cms.hhs.gov, downloaded November 4, 2008

November 21, 2008

To: Dr. Barbara Langner
Kansas Health Policy Authority

From: Richard Cram
Director of Policy & Research

Re: Study for Joint Oversight Committee on Health Policy

As part of a comprehensive study of health care benefits-related topics, the Department of Revenue was asked to compile a summary of information on state tax incentives or credits to encourage expansion of affordable commercial health insurance coverage, including the design and level of participation in those programs. The Department solicited information responsive to this request from other state revenue departments through the Federal Tax Administrators listserve. The information below summarizes the responses received from the participating states, as well as research of state tax laws for those states not responding.

Kansas

The small employer health insurance credit, K.S.A. 2006 Supp. 40-2246, provides a tax credit to small employers that have established health benefit plans or health savings accounts for employees. As a condition to participation as a member of any small employer health benefit plan, an employer shall not have contributed within the preceding two years to any health insurance premium or health savings account on behalf of an employee who is to be covered by the employer's contribution. The credit is the lesser of \$70 per month or the actual amount paid per eligible covered employee for the first 12 months of participation, the lesser of \$50 per month or the actual amount paid per eligible covered employee for the next 12 months of participation, and the lesser of \$35 per month or the actual amount paid per eligible covered employee for the next 12 months of participation.

Tax Year 2006 data and historical data is as follows:

Tax Year	Number of Filers	Tax Expenditure
2006	446	\$446,739
2005	159	\$212,651
2004	107	\$120,751
2003	89	\$131,587
2002	71	\$115,704

Under K.S.A. 79-32, 213, an employer of any member of the Kansas National Guard is allowed a non-refundable income tax credit for amounts paid for health insurance for such member and family during any period of state active duty in excess of 30 days if the employer is not otherwise required to pay for such insurance. Any unused credit can be carried forward until used. Due to confidentiality restrictions (5 or fewer claimants), data on credit usage is not available.

Alabama

Effective January 1, 2009, Alabama has enacted a small business health insurance deduction. Businesses with less than 25 employees will receive a tax deduction on their Alabama income tax return for 150% of the premiums paid for certain employees' health insurance. The increased deduction is for premiums paid on behalf of employees that earn less than \$50,000 in wages and whose Alabama Adjusted Gross Income for the year is \$75,000 or less (\$150,000 MFJ) for the applicable year. Those employees, viz., "Qualified Employees," will also be allowed to deduct 150% of their share of the insurance premiums. Given the fact that 100% of their premiums are currently excluded from taxable wages, Qualified Employees will only deduct an additional 50% on their Alabama individual income tax returns.

Since this benefit becomes effective in 2009, no data is available on usage.

Arizona

The Health Insurance Premium Tax Credit was established September 21, 2006 as a tax credit against the premium tax liability incurred by a health care insurer for insuring individuals and small businesses who were not previously covered by health insurance. Health care insurers that enroll an individual or small business certified as eligible by the Department of Revenue (DOR) pass the tax credit savings along by deducting the amount of the tax credit from the premium charged to the individual or small business for which the credit is taken. The total amount of the Health Insurance Premium Tax Credit is capped at \$5 million per year.

For coverage issued to an individual, the amount of the credit is based on the lesser of \$1,000 on a single person, \$3,000 for family coverage or \$500 for a dependent child or 50% of the annual premium.

For a small business, the amount of the credit is based on the lesser of \$1,000 for a single employee or \$3,000 for an employee electing family coverage or 50% of the annual premium.

The individual or small business must obtain health insurance within 90 days from the Certificate issued date or the Certificate expires. An individual or small business can participate in the program for three years as long as they continue to meet the eligibility requirements. In addition to not having health insurance for the last six months, an individual cannot earn more than 250% of the federal poverty level and a small business that has been in existence for one year must have at least 2 employees but not more than 25. See § 20-224.05 (for the Department of Insurance) and § 43-210, 41-1525 (for the Department of Revenue).

From September 21, 2006 through October 7, 2008, the DOR has issued 1,195 Certificates of Eligibility (166 for individuals and 1,029 for small businesses). Of the 1,195 Certificates, 502 (42%) have expired without notification of enrollment and 77 will not renew their Certificate in year two or year three leaving 616 active Certificates.

The total reserved for Certificates of Eligibility is the lesser of \$5,000,000 or 50% of the annual health insurance premium. The statutory credit allowance is based on 1,739 applying for single coverage, 1,085 applying for family coverage, and 12 applying for dependent coverage. The total amount reserved includes \$1,075,000 for 125 Certificates that are pending notification of renewal for year two or three and \$850,000 for 108 new Certificates that are pending notification of enrollment. There are currently 26 applicants on the waiting list. To date, the DOR has issued credit certificates to eleven health insurance carriers of \$341,881.84 for 2006, \$3,532,654.93 for 2007, and \$3,026,172.73 for 2008.

Colorado

Under Sec. 39-30-105, Colorado provides a tax credit for new business facility employees. One of the conditions for claiming the credit is that for any new business facility employee, the employer must provide a health insurance program and contribute at least 50% or more of the total cost of the insurance. No usage data is available to show the effect, if any, of this requirement.

Georgia

Under 110-9-1-.03(3), one of the conditions for a business enterprise to qualify for any job tax credits is that it must make available to all employees filling the new or additional new full-time jobs. However, there is no requirement for the business to pay for all or part of such health insurance coverage. No usage data is available to show the effect, if any, of this requirement.

Idaho

Under Section 35.01.01.746.01, an employer is eligible for an income tax credit of up to \$1,000 per new employee, if the wages and benefits for the new employee meet certain criteria, including eligibility for the new employee to receive employer-provided coverage under an accident and health plan meeting certain conditions. No usage data is available to show the effect, if any, of this requirement.

Indiana

Under IC 6-3.1-31-8, effective January 1, 2007, an eligible taxpayer who makes health insurance available to the eligible taxpayer's employees and their dependents through at least one health benefit plan is entitled to a credit against the taxpayer's adjusted gross income tax, financial institutions tax, or insurance premiums tax liability for the first two taxable years in which the taxpayer makes the health benefit plan available. To be eligible for the credit, (1) the employee's participation in the health benefit plan must be at the employee's election and, (2) if an employee chooses to participate in the plan, the employee should be able to pay the employee's share of the cost of the plan using a wage assignment authorized under IC 22-2-6-2. A taxpayer claiming the credit must continue to make health insurance available to the taxpayer's employees through a health benefit plan for at least 24 consecutive months beginning on the day after the last day of the

taxable year in which the taxpayer first offers the health benefit plan. If the taxpayer terminates the health benefit plan before the expiration of the 24-month period, the taxpayer must repay the Department the amount of the credit received. The credit allowed in each of the first two taxable years equals the lesser of \$2,500 or \$50 multiplied by the number of employees enrolled in the health benefit plan during the taxable year. If the credit amount in a taxable year exceeds the taxpayer's state tax liability for that taxable year, the taxpayer can carryover the excess to the following taxable years. The amount of the credit carryover from a taxable year must be reduced to the extent that the carryover is used by the taxpayer to obtain an identical credit for any subsequent taxable year. Taxpayers are not entitled to a carryback or a refund of any unused credit. No usage data was provided.

Iowa

Iowa has a special "above the line" deduction for health insurance and dental insurance premiums. Following is a description of this deduction from Iowa's online instructions.

Line 18 IA1040. HEALTH AND DENTAL INSURANCE DEDUCTION.

Enter 100% of the amount paid for health and dental insurance premiums. This includes all supplemental health insurance, such as Medicare B supplemental medical insurance and Medicare D voluntary prescription drug insurance program (not "Medicare tax withheld" on your W-2). 100% of health insurance premiums for long-term nursing home coverage qualifies for the health insurance deduction and is not subject to Schedule A limitations. It is typically to your advantage to take the deduction on line 18 instead of Schedule A, due to the Schedule A reduction of medical and dental expenses by 7.5% of Federal AGI. Schedule A may not contain any health or dental insurance premiums which were used as a deduction on line 18.

Do not deduct pretax premiums

This deduction is not available to individuals who have paid health or dental insurance premiums on a pretax basis. Pretax occurs when an employer subtracts the amount of the health or dental insurance premium from an employee's gross wages before withholding Federal and state income taxes. See your payroll department if you do not know whether or not your health or dental insurance was paid on a pretax basis.

Married Separate Filers:

If one spouse is employed and has health or dental insurance premiums paid through his/her wages, that spouse will claim the entire deduction. If both spouses pay health or dental insurance premiums through their wages, each spouse will claim what that individual paid.

If both spouses have self-employment income, the deduction for self-employed health or dental insurance must be allocated between the spouses in the ratio of each spouse's self-employment income to the total self-employment income of both spouses. If health or dental insurance premiums are paid directly by one spouse, that spouse will claim the

entire deduction. If both spouses paid through a joint checking account, the deduction would be allocated between the spouses in the ratio of each spouse's net income to the total net income of both spouses. For this net income calculation, do not include line 18, the health or dental insurance deduction.

Iowa did not provide any usage data.

Kentucky

Kentucky (KRS 141.010(10)(k)) provides an exclusion from taxable income of health insurance premiums of the taxpayer, taxpayer's spouse or dependents, if not otherwise (i.e., under federal income tax law) already excluded from taxable income. No usage data was provided.

Louisiana

Under L.R.S. 47:287.759.A, Louisiana provides to a contractor or subcontractor for construction of a public works project an income tax credit of 5% on 40% of the contract amount received in a tax year if 85% of the full-time employees of each contractor are offered health insurance coverage and each contractor pays 75% of the total premium for the health insurance coverage for each full-time employee who chooses to participate and pays not less than 50% of the total premium for health insurance coverage for each dependent of the full-time employee electing for such coverage. The credit is statutorily capped at \$3 million per year. No usage data was provided.

Maine

Under Sec. 5219-O, A taxpayer constituting an employing unit that employs fewer than 5 employees is allowed an income tax credit for the lesser of 20% of dependent health benefits paid with respect to the taxpayer's low-income employees under a health benefit plan during the taxable year for which the credit is allowed or \$125 per low-income employee with dependent health benefits coverage. The taxpayer must pay at least 80% of the health insurance costs of the low-income employee and at least 60% of the cost of dependent health benefits for children under 19 years of age who are covered under the health benefit plan and who are dependents of a low-income employee. The amount of the credit that may be used by a taxpayer for a taxable year may not exceed 50% of the state income tax otherwise due under for that year. The unused portion of any credit may be carried over to the following year or years for a period not to exceed 2 years. No usage data was provided.

Montana

Under M.C.A. 33-22-2006, a refundable credit against Montana corporation license tax is available to small businesses (between 2 and 9 employees, with salaries for each not exceeding \$75,000) to assist in paying for group health insurance. An eligible employer that does not receive premium assistance payments or premium incentive payments through the small business health insurance pool may claim the credit. The credit is equal to \$100 each month for each employee and \$100 each month for each employee's spouse (if the employer covers the spouse), if the average age of the group is 45 years of age or older; and not more than \$40 each month for each covered dependent, not to exceed two

dependents of an employee in addition to the employee's spouse. An employer may not claim a credit in excess of 50% of the total premiums paid by the employer for the qualifying small group, for premiums paid from a medical care savings account, or for premiums for which a deduction is claimed in computing corporation license or personal income tax. No usage data was provided.

Nevada

Under N.R.S. 360.750, the Commission on Economic Development is given the authority to partially abate taxes applicable to new or expanding businesses meeting certain criteria, including providing a health insurance plan for all employees that includes an option for health insurance coverage for dependents. No usage data was provided.

North Carolina

Under Sec. 105-129.16E, G.S., effective for the 2007 through 2009 taxable years, small businesses with fewer than 26 employees are eligible to claim a small business health insurance income or franchise tax credit if they pay at least 50% of the premiums for health care coverage that equals or exceeds the minimum provisions of the basic health care plan of coverage recommended by the Small Employer Carrier Committee, for all eligible employees, or if its employees have qualifying existing coverage. The credit is \$250 per employee or the cost of coverage, whichever is less. The credit only applies for employees whose annual salary does not exceed \$40,000. No usage data is available.

Oklahoma

Under the Oklahoma Quality Jobs Program, the Oklahoma Department of Commerce can award quarterly cash payments to qualifying companies. One of the qualification conditions includes offering basic health insurance coverage to all employees whose pay is included in new payroll figures. Employees must not pay more than 50% of the premium. No usage data was provided to show the effect, if any, of this requirement.

Pennsylvania

Pennsylvania provides a personal income tax exemption for contributions made to Health Savings Accounts and Archer Medical Accounts, consistent with the federal treatment of such accounts. (Unlike Kansas, Pennsylvania taxable income base is not based on Federal Adjusted Gross Income. This is one of the few deductions against income that Pennsylvania allows.)

The latest estimate of usage is 56,000 individuals claiming the exemption with about \$6 million in lost revenue. No actual data is available yet. Pennsylvania will be publishing actual figures from TY2006, and the figures are expected to be lower than the estimate.

Texas

INSURANCE TAX--Beginning in 2003, Texas allowed the formation of health group cooperatives for the purchase of employer health benefits. Texas has a two-year tax exemption from premium and retaliatory tax for an insurer that provides coverage to a health group cooperative for premiums received for employees or their dependents who were previously uninsured. The exemption applies to a cooperative employer member

that did not have insurance coverage for the 63 days immediately preceding the effective date of insurance coverage purchased through the cooperative. Texas Insurance Code, Chapter 1501.

FRANCHISE TAX--Small employers that have not provided health care benefits to any of its employees in the preceding year and who elect to subtract compensation to calculate margin for purposes of the Texas franchise tax, may subtract an additional amount equal to:

- 50% of the cost of health care benefits provided to its employees for the first twelve-month period on which margin is based in which the entity provides the health care benefits and

- 25% of the cost of health care benefits provided to its employees for the second twelve-month period on which margin is based in which the entity provides the health care benefits. Texas Tax Code, Chapter 171.

PROPERTY TAX--As of 2001, school districts may attract development by offering a tax credit and an eight-year limitation on appraised property value for the maintenance and operations portion of the school district property tax. The school district may approve qualified property in an area designated as a reinvestment zone or an enterprise zone provided that all of the qualified property is located within the designated zone.

To grant a value limitation for property in a reinvestment zone, the designation must be "reasonably likely" to:

- increase primary employment in the zone or
- attract major investment in the zone that would benefit property values and contribute to regional economic development.

In exchange for the appraised value limitation and tax credit, the property owner must agree to create a specific number of jobs and build or install specific type of real and personal property of a certain value. At least 80% of the jobs created must be covered by a group health plan.

The property must be devoted to manufacturing, research, and development; a clean coal project as defined in the Water Code; an advanced clean energy project as defined in the Health and Safety Code; renewal energy electric generation; electric power generation using integrated gasification combined cycle technology; or nuclear electric power generation. Texas Tax Code, Chapter 313.

Texas did not provide any usage data for the above programs.

Utah

The Utah code reference is Section 59-10-1023 for a non-refundable income tax credit toward health insurance costs, if those are not claimed as a credit or deduction on the federal return or not excluded from federal income. Roughly the credit can be \$300,

\$600, or \$900 depending on the family structure. This is a new credit and no usage data is available. (Utah replaced a deduction with a credit.) The latest cost estimate is between \$8 and \$9 million, based on a previous deduction with 67,000 claims and total deductions of \$142 million (2006 data).

West Virginia

The Economic Opportunity Tax Credit statute was amended (W.Va. Code 11-13Q-22) in 2008 to permit businesses engaged in certain selected activities* that create jobs, but not at the levels** required for other parts of the statute, to claim credit equal to \$3,000 per year per new job for a period of five years. The requirements for the new job to qualify are as follows:

1. Pays at least \$32,000 annually,
2. Provides health insurance and may offer benefits including child care, retirement, or other benefits, and
3. Is a full-time, permanent position.

The amendment is effective January 1, 2009, so no usage information on how many businesses will claim the credit is available.

*The Economic Opportunity Tax Credit is only available (W. Va. Code 11-13Q-19) to taxpayers engaged in:

Manufacturing,
Information processing,
Warehousing,
Goods distribution,
Destination-oriented recreation and tourism, and
Research and development

**The minimum jobs creation requirements by credit type:

Regular and High Technology Manufacturer	20
Headquarters relocation	15
Small business	10

Wisconsin

Wisconsin does not offer tax credits to employers for medical care insurance coverage; however, it provides an individual income tax deduction for all or a portion of the medical care insurance premiums paid by self-employed, unemployed, employees whose employer provides no medical care insurance and employees whose employers pay a portion of employees' medical care insurance. Specifically, deductions are allowed for:

1. 100% of medical care insurance premiums paid by self-employed individuals (not to exceed net earnings from a trade or business).
2. 100% of medical care insurance premiums paid by an individual who is the employee of another person if the individual's employer pays no amount of money toward the individual's medical care insurance (not to exceed the individual's wages, salaries, tips and other employee compensation).

3. Tax Year 2007: 33.3% of the medical care insurance premiums paid by an individual with no employer and no self-employment income. This increases to 66.7% in tax year 2008 and 100% in tax year 2009.
4. Tax Year 2008: 10% of the medical care insurance premiums paid by an individual who is the employee of another person if the employer pays a portion of the individual's medical insurance. This increases to 25% in tax year 2009, 45% in tax year 2010 and 100% in tax year 2011.

Wisconsin provided data for tax years 2005 and 2006. The medical insurance deductions are lumped together on the income tax form, so they do not have separate data.

In tax year 2005, approximately 35,000 claimed medical insurance deductions in the amount of \$76.5 million. The deduction was for self employed health insurance (to the extent not already deducted from federal income) and 50% of health insurance of employees whose employers don't contribute to health insurance.

In tax year 2006, approximately 42,000 claimed deductions in the amount of \$107.1 million. The deduction was for self employed health insurance (to the extent not already deducted from federal income) and 100% of health insurance of employees whose employers don't contribute to health insurance.

Please let me know if you have additional questions or need further information.

**KANSAS INSURANCE DEPARTMENT
LEGISLATIVE COORDINATING COUNCIL
STUDIES #11 AND 12**

HSAs, HDHPs, AND SECTION 125 PLANS

and

**INSURER PROGRAMS PROMOTING WELLNESS,
HEALTH, AND DISEASE PREVENTION**

January 9, 2009

INTRODUCTION

Public Health Studies

In May 2008 the Conference Committee on H. Sub. for SB 81 requested studies on a number of topics initially considered as part of the legislation. On July 9, 2008 the Legislative Coordinating Council (LCC) approved a number of these studies to be conducted by the Kansas Health Policy Authority (KHPA) during the 2008 Interim period, with such studies to be provided to the Joint Committee on Health Policy Oversight on or before November 1, 2008. On August 29, 2008 KHPA confirmed, in a letter addressed to the LCC, that on August 14, 2008 the Joint Committee had approved an extension of the delivery date for the studies to the first day of the 2009 Legislative Session (on or before January 12, 2008). The LCC acknowledged this extension on October 13, 2008 and also approved KHPA's assignment of certain studies to various agencies. The following two studies were assigned to the Kansas Insurance Department:

- 1. Study encouragement of HSAs, HDHPs, and Section 125 plans to expand affordable commercial insurance**
- 2. Study allowing insurers to provide incentives in return for participation in programs promoting wellness, health, and disease prevention to expand affordable commercial insurance**

HEALTH SAVINGS ACCOUNTS, HIGH DEDUCTIBLE HEALTH PLANS & SECTION 125 PLANS

What is a Health Savings Account?

A health savings account (HSA) is a savings product that can be used as an alternative to traditional health insurance and which allows one to pay for current health expenses and save for future qualified medical and retiree health expenses on a tax-free basis. In order to take advantage of an HSA, you must also be covered by a high deductible health plan (HDHP) but must not be covered by other health insurance that is not an HDHP. In general, an HDHP will cost less than traditional health insurance, so the money saved on insurance can be put into the HSA. The money placed in the HSA is controlled by the owner and decisions regarding how the money is spent are made by the owner, without relying on a third party or a health insurer. The owner may also decide what types of investments to make with the money in the account in order to make it grow, including stocks, bonds, mutual funds, and certificates of deposit.

What is a High Deductible Health Plan?

As stated above, if you want to open an HSA you must also have a high deductible health plan. An HDHP, sometimes referred to as a "catastrophic" health insurance plan, is a less expensive health insurance plan with a high "deductible", which means it doesn't cover the first several thousand dollars of health care expenses you incur but will generally cover your expenses once that deductible is met. The intent is that the funds in the HSA will help pay for the expenses that your HDHP does not cover.

The HDHP policy does not have to be in the name of the owner of the HSA, as long as the HSA owner has coverage under the HDHP policy. This situation might arise in cases where the HSA owner has coverage under an HDHP in his or her spouse's name.

Setting Up an HSA

HSAs can be set up with banks, credit unions, insurance companies, and other approved companies. Employers are also permitted to set up plans for their employees. There are no income limitations that affect HSA eligibility. However, if you do not file a federal income tax return, you may not receive all the tax benefits that HSAs offer.

How Much Does It Cost?

An HSA is not something you purchase but is a savings account, similar to an IRA, into which you can deposit money on a tax-preferred basis. The only additional expense is the cost of purchasing an HDHP, which will cover you should your medical expenses exceed the funds available in your HSA. However, depending on where the HSA is established, there may be additional fees for administration of the account.

For 2008, in order to qualify to open an HSA, you were required to purchase an HDHP with a minimum deductible of \$1,100 (for individual-only coverage) or \$2,200 (for family

coverage). The annual out-of-pocket expenses, including deductibles and co-payments, could not exceed \$5,600 (individual-only coverage) or \$11,200 (family coverage). HDHPs are permitted to have first dollar coverage (no deductible) for preventive care but may also apply higher out-of-pocket limits (co-payments and insurance) for non-network services.

Once funds are deposited into an HSA, they can be used to pay for qualified medical expenses tax free. The funds in the account roll over automatically each year and there is no time limit on using the funds. If your HDHP is cancelled or terminated, the funds in the HSA can still be used to pay for qualified medical expenses tax-free but no additional contributions can be made to the HSA account for the period you are not covered by an HDHP.

Eligibility

As state above, in order to be eligible for an HSA, an individual must be covered by a qualified HDHP and must not be covered by other health insurance that is not an HDHP. However, certain types of insurance, such as automobile, dental, vision, disability, and long-term care insurance do not jeopardize your eligibility for an HSA. You may also have health insurance coverage for a specific disease or illness, such as cancer, as long as that insurance pays a specific dollar amount when the policy is triggered. Wellness programs offered by your employer are also permitted if they do not pay significant medical benefits.

Individuals are not eligible for an HSA after they have enrolled in Medicare. However, if you had an HSA before you enrolled in Medicare you may keep it and continue to use it but may no longer make contributions to the account. Individuals who have received any health benefits from the Veterans Administration or one of their facilities, including prescription drugs, are also ineligible for an HSA.

HSA Funding

Contributions to HSAs can be made by individuals, their employers, or both. For 2008 the maximum annual HSA contribution was \$2,900, for individual only HDHP coverage, and \$5,800 for family coverage, regardless of the amount of the HDHP deductible. For 2009, these amounts increase to \$3,000 for individual coverage and \$5,950 for family coverage. If you are age 55 or older, you may also make additional "catch-up" contributions each year until you enroll in Medicare. For 2008, the catch-up contribution amount is \$900 and for 2009 and after the catch-up amount is \$1,000.

Contributions may be made to an HSA in a lump sum or in any amounts or frequency desired. However, the account trustee (bank, credit union, insurer, etc.) may have minimum deposit and balance requirements. Contributions made by employers are aggregated with those made by the HSA account holder to determine whether the maximum contribution has been made.

Tax Benefits

Personal contributions to an HSA provide an "above-the-line" deduction, which means the HSA account holder is permitted to reduce his or her taxable income by the amount contributed to the HSA. The account holder is not required to itemize deductions in order to qualify for this tax benefit. If an employer makes a contribution to the HSA, the contribution is not taxable to the employee.

If your employer offers a "salary reduction" plan, also known as a Section 125 plan or cafeteria plan, you may also make contributions to your HSA on a pre-tax basis but may not claim the "above-the-line" deduction for that same contribution.

Self-employed persons are not permitted to contribute to an HSA on a pre-tax basis but may contribute with after-tax dollars and take the above-the-line deduction.

Use of HSA Funds

HSA funds can be used to pay for any "qualified medical expense" for yourself, your spouse, or a dependent, even if the expense is not covered by your HDHP. For example, most health insurance plans do not cover the cost of over-the-counter medicines, but HSA funds can be used for these expenses. As long as HSA funds are used for qualified medical expenses, the money spent is tax-free.

When determining whether an expense qualifies as a "qualified medical expense," HSA account holders can refer to IRS Publication 502, available at the Internal Revenue Service website (www.irs.gov). However, in general, the expense has to be primarily for the prevention or alleviation of a physical defect or illness. If HSA funds are used for other than qualified medical expense, the expenditure will be taxed and, for individuals who are not disabled or over age 65, subject to a 10% tax penalty.

The HSA account holder is responsible for keeping track of contributions made to the account and expenditures. If you have not met your HDHP policy deductible you will be expected to pay for 100% of the amount agreed to be paid by your insurance policy to the physician, either at the time services are provided or when you receive a bill from your physician.

What Are Section 125 Cafeteria Plans?

Section 125 cafeteria plans, also referred to as flexible benefit plans or Section 125 plans, are employer sponsored employee benefit plans that allow employees to obtain benefits on a pre-tax basis. Congress provided for cafeteria plans in 1978 under IRS Code Section 125.

The primary benefit for employers is a potential savings in payroll taxes. For employees, the benefits include income tax savings, increased take-home pay, and increased morale. In general, the administrative costs of establishing and maintaining a Section 125 plan are minimal compared to the potential tax savings.

Premium Only (POP) Section 125 Cafeteria Plans

A premium only plan, also known as a POP, is a popular type of Section 125 plan. A POP plan helps reduce a company's costs by allowing its employees to pay for qualified health care premiums with pre-tax dollars.

POP Benefits

For employers, the benefits include:

- Savings on payroll taxes when employees make pre-tax contributions, which ultimately decrease the amount of taxable pay
- Ability to deduct POP fees as a business expense

For employees, the benefits include:

- Savings on cost of qualified insurance premiums since employee contributions are made with pre-tax dollars
- Increased take-home pay as a result of reduced taxes

How Can Employers Be Encouraged to Use HSAs, HDHPs, and Section 125 Cafeteria Plans?

The Kansas Insurance Department (KID) provides a number of resources for small employers that contain information regarding HSAs. Such information is included in KID's Small Business Packet, which is distributed to small businesses seeking information about the different types of insurance needed for their companies. This information is also provided on KID's public website at 222.ksinsurance.org/consumers/hsa.htm. The KID website also provides a regularly updated list of banks that offer HSAs. Periodically Commissioner Praeger has discussed HSAs in articles provided to media throughout the State, which are published in local newspapers. Finally, KID recently completed an insurance Primer that will be available for distribution in early 2009. This Primer contains information about the various types of insurance regulated at both the state and federal level and provides specific information regarding HSAs and tax credits available to employers who make contributions to HSAs on behalf of their employees.

House Substitute for Senate Bill 81, which was passed during the 2007-2009 Legislative Session, included a number of provisions to expand the use of Premium Only Section 125 Plans by Kansas employers. In New Section 1, insurers doing business in Kansas are now required to provide employers with the option of establishing a premium only cafeteria plan and amended the definition of "health benefit plan" to include Section 125 cafeteria plans. In New Section 2, the Legislature also encouraged employers to "offer the option of paying all or any portion of the health insurance premium or the option of receiving health insurance coverage through a high

deductible health plan and the establishment of a health savings account." Finally, in Section 16 of SB 81, the Legislature authorized the Kansas Health Policy Authority to provide grants to small employers "for the purpose of establishing a cafeteria plan" and directed the Authority to develop and implement a program to ensure that small employers are aware of the grant program and understand the benefits of establishing cafeteria plans.

Recommendation

Although there is abundant information available from the Kansas Insurance Department and through the Internet regarding health savings accounts, high deductible health plans, and Section 125 cafeteria plans, many small employers may still be unaware of the existence and benefits of such plans. Greater promotion in the media or education for small employers regarding the costs and benefits of HSAs, HDHPs, and Section 125 Plans through small business associations or a state-sponsored clearinghouse, like the development program described in SB 81, may result in expanded use of these benefits. However, small employers may still be reluctant to establish such programs for their employees for a number of reasons.

First, small employers, that typically do not have human resource departments or a human resource person on staff, may feel overwhelmed or unprepared to take on the responsibility of establishing and maintaining these types of benefit plans for their employees. In some cases there may be misunderstandings regarding the cost of establishing such programs or concerns regarding the amount of time necessary to administer these programs.

Second, although HSAs, HDHPs, and Section 125 Plans provide significant benefits to both employers and employees, either the employees or the employer must be willing and able to make the necessary monetary contributions to establish and maintain these plans. In the case of HSAs, both the employee and the employer are permitted to make contributions to the employee's HSA, but the contributions needed to provide sufficient funds to cover the deductible of the employee's HDHP, generally in excess of \$1,000, may be difficult or impossible for both parties. In these cases, expanded use of such plans might be possible if subsidies were provided to small employers or individuals to reduce the costs associated with HSAs, HDHPs, and Section 125 Cafeteria Plans for their employees.

WELLNESS, HEALTH AND DISEASE PREVENTION PROGRAMS

In general, Kansas insurance law does not prohibit insurers from providing incentives to their insureds for participation in wellness or disease prevention programs and the inclusion of such programs in contracts of health insurance issued to Kansas insureds is routinely approved by the Kansas Insurance Department. However, under K.S.A. 40-2404(8)(a), insurers are prohibited from knowingly permitting, offering or making any contract of accident and health insurance that contains any inducement to purchase, discounted premiums, special favor or advantage, or any "valuable consideration or inducement" unless it is "plainly expressed in the insurance contract."

When reviewing and approving contracts of insurance that contain these types of programs, KID's policy examiners review the type of incentives or special benefits that an insurer is proposing to offer to Kansas insureds to determine whether the incentives or special benefits are clearly described in the policy and apply to all insureds in a non-discriminatory fashion. In cases where the policy examiner asks for additional clarification or language to be included in the policy form or an associated rider, insurers regularly modify the contracts to provide the clarity needed to insure that the incentives and benefits are clearly described.

In the past KID has approved wellness and disease prevention programs that include:

- Health risk assessments
- Personalized health living action plans
- Healthy weight or weight management programs, including dietitian services
- 24 hour nurse access
- Wellness counseling
- Discounts for fitness club memberships and home exercise equipment
- Complementary "natural" health care services, such as acupuncture, chiropractic care, and massage therapy
- Reduced deductibles and co-payments for preventive care services, such as annual physical, eye, and hearing exams, routine dental visits, flu shots and other vaccinations.

KANSAS HEALTH POLICY AUTHORITY

LEGISLATIVE COORDINATING COUNCIL STUDIES

#13 – Young Adult Policy Options and #15 – Small Business Health Reform Options

INTRODUCTION

In 2008, the Kansas Legislature's Joint Committee on Health Policy Oversight requested the Kansas Health Policy Authority conduct a number of studies. Two of the studies requested, *#13 - Young Adult Policy Options*, and *#15 – Small Business Health Reform Options*, are addressed here. We have provided the Committee with excerpts from KHPA's 2008 Legislative Recommendations that are relevant to the topics addressed here in order to provide the Committee with the continuum of policy development from 2008 to 2009.

Review of the 2008 Legislative Session – KHPA Discussions on Health Care Reform Options

To place the 2009 Legislative studies in perspective, it is important to review the analyses completed in preparation for the 2008 Legislative Session. In advance of the 2008 Legislative Session, KHPA had undertaken a comprehensive health reform analysis, designed to examine the most effective ways to fundamentally improve the health of all Kansans. KHPA produced a comprehensive set of health reform recommendations. The third set of reform recommendations, Providing and Protecting Affordable Health Insurance are most relevant to this discussion.

P3 (1) Providing and Protecting Affordable Health Insurance: Access to Care for Kansas Children and Young Adults¹

Policy

For children, target and enroll the children up to 200% FPL currently eligible but not enrolled in HealthWave 19 and 21. For young adults, change Kansas insurance law to allow parents to keep young adults (through age 25 years) on their family insurance plan and develop specific Young Adult Plans (YAPs) that provide health care insurance options with limited benefit packages and lower premiums. (Note: In the United Methodist Health Ministry Fund report, YAPs are discussed within the third initiative describing voluntary insurance market reforms.)

The policy would include specific targets and timelines for the improved enrollment for children and young adults that if not met, would trigger additional review by the KHPA Board. This trigger mechanism will initiate the KHPA Board's review of further policy options, including the consideration of mandating health insurance coverage for children in Kansas.

Background

States that have been successful at increasing enrollment penetration for eligible but not enrolled in government-funded health care have extended their outreach programs operationally and included web-based enrollment, public-program coordination/collaboration, school-based outreach programs, and out-stationing eligibility workers with culturally competent community partners. Each of these efforts entails moving the point of engagement with the child or family into the family's everyday life through a known contact, local geography or both.

¹ The recommendations contained in *P3 Providing and Protecting Affordable Health Insurance* are part of the Kansas Health Policy Authority (KHPA) Board Updated Health Reform Recommendations, released January 30, 2008. This has been included to add perspective to the topics presented in the 2008 Legislative Session and give insight into the selection process of reform options that have been modeled since that time in preparation for the 2009 Legislative Session.

Just as with the broader uninsured population, there are many reasons young adults lack health care coverage, but key differences of the young adult population can be capitalized upon. First, young adults are more likely than their uninsured older counterparts to live at home, be supported by their parents, or be enrolled in secondary education institutions. Secondly, young adults typically enter the workforce in lower paying jobs and are more likely to work in jobs where health insurance is not offered. Third, young adults are, in general, healthier than their older counterparts and may see less benefit in paying top dollar for comprehensive health insurance plans. A change in Kansas insurance law to allow parents to keep young adults on their family insurance plan through age 25 would assist in providing transitional insurance to young adults as they leave home, enter the workforce, and gain employer-sponsored coverage. Development of YAPs – health insurance products specifically designed for adults aged 19-24 years old – would be a voluntary program aimed at offering a market specific insurance product with a limited benefit package and correspondingly lower premiums. These plans would be developed by the state in conjunction with private health insurers. This again would require changes to Kansas insurance law. Kansas would need to develop regulations covering areas such as who could sell the product, minimum coverage standards, and rating requirements for the product.

Stakeholder Input

Stakeholder input and KHPA Board deliberations focused on increasing access to health services by maximizing the use of existing health insurance coverage. The KHPA Board voiced strong support for policies to insure all children in Kansas have access to health insurance. Aggressive outreach and web-based enrollment is seen as a first step in ensuring access. The KHPA Board focused on developing strategies for children and young adults encouraging them to enroll in existing insurance currently available to them. Another important consideration discussed by the Board was to begin to develop a culture of valuing insurance early on in all Kansans. The Board felt it important to have children and young adults experience the value of health insurance starting an early age.

Population Served

15,000 additional children would enroll in Medicaid and approximately 5,000 additional children would enroll in SCHIP as a result of an extremely visible and effective outreach, web-based enrollment and facilitated enrollment processes specifically targeting uninsured lower income children eligible for public programs. Developing Young Adult Plans (YAPs) with limited benefits targeted at young adults ages 19-24 years old would insure 15,000 additional young adults.

Cost Estimate

Children and Young Adults

- \$22 million All Funds (AF)
- \$14 million State General Funds (SGF)

Financing Considerations

For the child-focused targeted outreach and web-based enrollment, effective new enrollment rates are projected to be high compared to the typical range of take-up rates assumed for public programs. Also, to employ these innovative strategies, the outreach costs per additional enrollee for these currently eligible but not enrolled children will be greater in comparison to Kansas' historical outreach costs per additional enrollee. For the creation of affordable YAPs, the challenge for Kansas health policy-makers is to develop the regulations so that they balance affordability with comprehensive coverage.

P3 (2) Providing and Protecting Affordable Health Insurance: Expanding Insurance for Low-Income Kansans

Policy

Expand population for the Premium Assistance program to include adults (without children) earning up to 100% FPL (\$10,210 annually).

Background

This voluntary program was aimed at integrating the poorest childless adults into the health care system by providing them with subsidized access to health care insurance. Adults without children do not fit within Medicaid's traditional eligibility categories, although the Centers for Medicare & Medicaid Services (CMS) have provided states with additional options within the Deficit Reduction Act (DRA). States have taken a variety of approaches to covering childless adults, typically either through state-only programs like Connecticut's State Administered General Assistance (SAGA) program or by pursuing waiver authority through the federal government and the CMS waiver process.

The structure for this initiative would be an expansion of the covered population eligible for Premium Assistance as specified in SB 11. The newly eligible individuals could be served within the same administrative structure that is being developed for the current SB 11 Premium Assistance program.

Stakeholder Input

Stakeholder input focused on leveling the playing field to assist low income Kansans' to getting access to health insurance.

Population Served

The population served are adults (without children) earning up to 100% FPL (\$10,210 annually). 39,000 low income Kansans would become insured.

Cost Estimate

Low Income Kansans

- \$119 Million AF
- \$56 Million SGF

Financing Considerations

The model allowed for joint financing between the state and federal governments, however stand-alone State financing is also an option. If the Governor and the Kansas Legislature made the policy decision to implement a state-only program, Kansas could implement a state-only program fairly quickly by building upon the existing Kansas public program infrastructure. However, if the policy decision is to pursue federal matching funds for childless adults, significant challenges may exist depending upon whether the State could pursue approval using flexibility through the Deficit Reduction Act (DRA) or whether the State would be required to pursue a waiver. If required to pursue a waiver, Kansas would need to determine the appropriate waiver vehicle to use. Regardless of the waiver vehicle and strategy selected, the second and perhaps the more vexing challenge would be meeting budget neutrality.

If Kansas chose to pursue a state-only program for childless adults, the price tag would be \$140 million for a fully implemented program (at the current take-up rates). Alternatively, to achieve CMS budget neutrality for a federal program waiver, the state would need to find reductions in federal spending on the order of approximately \$63 million annually (once the childless adults hit full enrollment).

P3 (3) Providing and Protecting Affordable Health Insurance: Affordable Coverage for Small Business

Policy

Help small employers better access health insurance by developing a voluntary health insurance clearinghouse to assist small employers to access health insurance and tax-preferred health insurance premiums through Section 125 plans. Stabilize and lower health insurance rates for the smallest and newest businesses by creating a new "micro-market" for sole proprietors and very small employers (VSG - one to ten employees) within the small group market. Establish a reinsurance program to spread the risk of this new micro-market among all carriers and the State.

Stakeholder Input

The KHPA Board received a tremendous amount of input describing the need to make coverage more accessible and affordable for small businesses. The input directed the KHPA Board to consider ways to further segment the small employer population into smaller sub-populations and to consider a Kansas-specific adaptation of a health insurance connector/exchange. The Board described this as a voluntary insurance clearinghouse to provide administrative functions to the small employer market.

Population Served

Overall, the new VSG market would insure 5,900 working Kansans and their families prior to the impact of the reinsurance program. The introduction of the reinsurance program and the subsequent drop in premium would result in an additional 6,000 working Kansans and their families insured. The newly established voluntary insurance clearinghouse will be available to assist all of Kansas' small employer groups but has no direct population impact.

Cost Estimate

Small Businesses

- -\$5 Million AF*
- \$1 Million SGF

(*Note: At the person level, the uncompensated care costs for the previously uninsured are reduced due to this change, hence the reduction in All Funds shown above.. Practically, however, at the program level, the State of Kansas will not change the state's Disproportionate Share Hospital reimbursement methodology.)

Marketplace Considerations

During the numerous discussions with the KHPA Board surrounding potential insurance market reforms, the concept of "Do No Harm" was introduced. In the context of health insurance market reform, "Do No Harm" conveyed the KHPA Board's desire to ensure that the market reforms being considered would only improve the workings of the admittedly complex health insurance market. To ensure the reforms "Do No Harm," substantial review of Kansas insurance law will need to take place to ensure a level-playing field exists in the context of the new markets proposed here for VSGs and YAPs. Due to the complex and inter-related nature of the health insurance market, equally as importantly is the need to consider the proposed reforms in the context of the larger health insurance market in Kansas.

Summary of the Updated Sequential Plan

The individual components of the Updated Sequential Model, as fully implemented, each decrease the number of Kansans without health care insurance.

Modeling results indicate the total effect of the Updated Sequential plan would be a 30% decrease in the number of uninsured Kansans (non-elderly).

Population Served

The number of uninsured Kansans would drop by 86,000, from 260,000 to 174,000 (Figure 12).

Children and Young Adults

- 20,000 more children would be insured through public program outreach.
- 15,000 more young adults would be insured due to new products being offered at the Insurance

Clearinghouse.

Low Income Kansans

- 39,000 more childless adults with incomes below 100% FPL would be insured through an expansion of the Premium Assistance SB 11 Program.

Small Businesses

- 12,000 more very small groups (sole proprietors and 1 to 10 employees) would be insured through the market combination and reinsurance efforts.
- Section 125 assistance would encourage small businesses to offer tax-preferred health insurance premiums.

After full implementation of the Updated Sequential option, Kansas will have one of the lowest uninsurance rates in the country with only 7% of Kansans lacking health care coverage.

Cost Estimate

While the individual components of the Updated Sequential Model, as fully implemented, each decrease the number of Kansans without health care insurance, the impact upon All Funds and State General Funds varies substantially (Figures 13 and 14).

Children and Young Adults

- \$22 Million AF
- \$14 Million SGF

Low Income Kansans

- \$119 Million AF
- \$56 Million SGF

Small Businesses

- -\$5 Million AF*
- \$1 Million SGF

(*Note: At the person level, the uncompensated care costs for the previously uninsured are reduced due to this change, hence the reduction in All Funds shown above.. Practically, however, at the program level, the State of Kansas will not change the State's Disproportionate Share Hospital reimbursement methodology.)

The net cost of the Updated Sequential plan is an increase in expenditures (AF) for non-elderly Kansans of \$136 million. After full-implementation of all three initiatives that make up the Updated Sequential plan, State General Fund expenditures would increase by \$71 million.

NEXT STEPS

The analyses discuss above were used to construct the 21 recommendations for health care reform presented by KHPA during the 2008 Legislative Session as part of SB 81. Of these recommendations, nine of the 21 were included in an Omnibus appropriations bill, and only one of the nine was funded by the Legislature. From this it was determined further discussion was needed regarding reform options present in the Updated Sequential Plan, particularly those addressing health insurance issues specific to the small business community. As a result, KHPA formed the Small Business Health Insurance Steering Committee (SBHISC) and tasked with Committee with representing the stakeholders in the small business market and working collaboratively with KHPA to provide recommendations for small business health insurance reform options to be presented in the 2009 Legislative Session.

Preparations for the 2009 Legislative Session – KHPA Discussions on Health Care Reform Options

The dialogue with the SBHISC yielded a plethora of recommendations from various stakeholders within the small business market; Kansas Insurance Department, health plan administrators, independent agents, and advocates. From the start, there were common themes in the responses from all participants, focusing primarily on affordability and cost containment. Both of these issues are interrelated, as in order for affordability to be sustained for any significant period of time, pressure from increasing costs must be relieved. The process considering various options for reform was comprehensive, but the feedback from the SBHISC as well as direction from the 2008 Legislative Session was for KHPA and its recommendations to be more focused for 2009. As a result, KHPA and srHS crafted the following reform options² to model for the 2009 Legislative Session:

- Section 125 – Mandate Section 125 Plans for all Small Employers
- Business Health Partnership (BHP) – Expand roles and responsibilities of BHP in leading Small Employer Reforms
- Reinsurance – Estimate cost of Subsidized Reinsurance to reduce cost and volatility of Small Employer Health Insurance Market
- Mini-Med – Estimate cost and enrollment due to offering Mini-Med policies
- Young Adults – Allow all Dependent Young Adults from 19-25 remain on Parent’s Insurance Coverage

2009 Legislative Studies – Joint Committee on Health Policy Oversight

As part of those deliberations and analyses conducted by KHPA in support of the SBHISC, in addition to the reform options listed above submitted to the KHPA Board, KHPA also completed the following analyses in response to the Joint Committee on Health Policy Oversight request for 2009 Legislative studies by KHPA:

- 13) A study allowing insurers to offer young adult policies with limited benefits and reduced premiums to expand access to affordable coverage; and***
- 15) Study health policy options to reduce the rate of uninsurance at Small Businesses, including the creation of a Small Business Health Policy Committee to assist small employers secure health insurance, allowing very small employers to obtain health insurance and making health insurance more affordable for small businesses and employees to expand affordable commercial insurance.***

The results of our studies are presented below.

² For more information on the reform approaches considered and modeled, please the presentation to the KHPA Board on November 18, 2008 entitled “*Small Business Health Reform Proposal*”.

13) Study allowing insurers to offer young adult policies with limited benefits and reduced premiums to expand access to affordable coverage

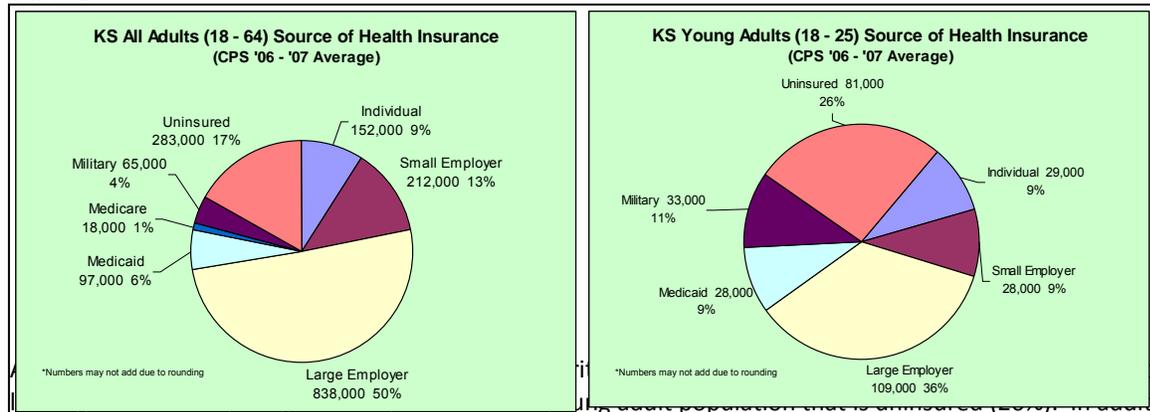
Purpose of this Study

The purpose of this study was to examine the impact on the number of uninsured young adults (ages 18-25) in Kansas by allowing insurers to offer policies specific to young adults with limited benefits and reduced premiums. In collaboration with the Small Business Health Insurance Steering Committee and the Kansas Health Policy Authority, schramm[®]raleigh Health Strategy (srHS) priced out a “Mini-Med” plan design with limited benefits. Premiums calculated reflected both the limited benefits and the underlying health risk for young adults. Based on the lower monthly premium and subsidies from the State srHS estimated how many additional young adults would purchase health coverage.

Insurance Status of Young Adults in Kansas

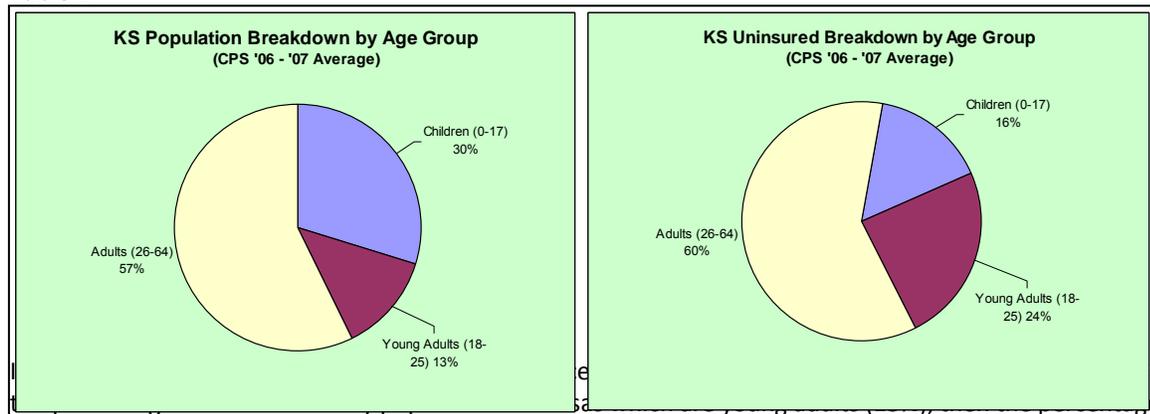
As an age group young adults have the highest rate of uninsurance in the state. According to an average of the 2006 and 2007 Current Population Surveys (CPS), there are an estimated 310,000 young adults living in Kansas as shown in Table 1. Of this amount, 229,000 currently have health insurance, while 81,000 are uninsured.

Table 1



young adults are less likely to have insurance through a large employer, the dominant insurance market in Kansas.

Table 2



uninsured young adults (24%) as it relates to all uninsured non-elderly in Kansas.

Mini-Med: Young Adult Limited Benefit Health Coverage

In contrast to the majority of products seen in the health insurance market, Mini-Med is not and should not be considered health insurance, but rather health coverage. In this instance Mini-Med is intended to provide an

affordable alternative for access to coverage through traditional sources in the private market. In order to prevent crowd-out from the private market and to target the uninsured srHS is assuming a 6 month “go-bare” provision, making a requirement for eligibility that enrollees have been uninsured for 6 months prior to enrollment. The Mini-Med plan has the following service specific dollar amount and service limitations:

Benefit	Limit (for a 12 month period)	Cost Share
Doctor Visits	12 Visits	
• PCP		\$15 Co-Pay
• Specialist		\$25 Co-pay
Prescription Drugs	Generic Only \$2,000 Maximum	\$10 Co-Pay
Inpatient	\$15,000 Maximum	\$100 Co-Pay
Emergency Room	2 Visits	\$50 Co-Pay
Outpatient Surgery	1 Visit	\$25 Co-Pay
Outpatient Other (Includes Lab/Radiology and PT/ST/OT services)	4 Services	\$25 Co-Pay
DME	\$1,000 Limit	\$0 Co-Pay
Maximum Annual Benefit	\$25,000	

Access and Affordability

The Mini-Med product is able to offer coverage at approximately \$122 per month, which is roughly 20% less than the cost of the typical insurance product purchased on the individual market, however with no deductibles or coinsurance. When comparing the premiums of Mini-Med and employer sponsored insurance (ESI), ESI is less expensive due to the employer typically covering 70%-80% of premium expense. Despite the economic advantage of purchasing ESI, young adult participation in ESI is low for two reasons:

1. The transient nature of employment seen in the young adult population typically does not allow them to be eligible for coverage through an employer; and
2. Many do not have employers who offer insurance or are willing to contribute its cost.

Even though in comparison to other policies Mini-Med is more affordable, it is not likely there will be a large portion of the uninsured young adults purchasing a Mini-Med program at full price. This can be explained by the large number of young adults that are considered either low income or are living under the Federal poverty level (FPL). People with lower income place more value to each dollar relative to their higher earning counterparts, therefore a 20% decrease in premium does not increase their propensity to purchase coverage if the resulting premium is still a significant portion of their monthly income. To address this issue srHS modeled the effects of a state subsidy for the premiums in this plan. Assuming state subsidization, enrollee contributions would range from \$5 to \$45 depending on income. srHS used an elasticity of demand function in an attempt to estimate how many of the uninsured young adults would purchase the Mini-Med product based on:

1. The current purchasing decisions of this population; and
2. The out of pocket expenditures associated with Mini-Med (includes both premium contribution and cost sharing).

Due to the factors listed above regarding the unlikely nature of uninsured young adults to purchase coverage, their demand was assumed to be relatively inelastic. The majority of studies done regarding elasticity of demand as it relates to health insurance state the average figure to be between -.500 and -.600, which would be considered inelastic. These studies have typically not targeted young adults, but the limited information available suggests this group to be more inelastic than their older counterparts, so to be conservative we assume a base elasticity of -.100.

Findings

The results showed that the number of uninsured young adults could be reduced using state subsidies. Due to the inelastic nature of young adults as it relates to purchasing health coverage, a significant reduction in price is necessary to provide enough incentive to purchase coverage. Assuming state subsidization as stated above, it is estimated over 8,000 previously uninsured young adults would purchase Mini-Med coverage, showing a 10% uptake of the eligible population. In addition, approximately 25% of new enrollment would come from those under the poverty level, and almost 70% would be those making less than 300% (FPL). State subsidization of this program would cost the state \$7,000,000 or about \$70 per enrollee, which, in relation to typical state subsidized coverage, is cost effective.

Feedback and Recommendations

This product operates under the principle that some coverage is better than no coverage. An individual who is uninsured seldom has regular access to a physician; this situation has the potential to lead to more serious health conditions. Mini-Med addresses this by making access to coverage affordable, allowing people to receive medical treatment as needed. An additional benefit to this policy would be showing young adults the value of health coverage, which can be useful in educating young adults new to the health insurance market. Taking a long-term approach is necessary in teaching future generations the importance having and utilizing health coverage. However, there is not universal agreement on the effectiveness of Mini-Med. The fact that there are limited benefits exposes enrollees to bear the risk of claims over \$25,000, which could leave them without coverage when the most serious medical conditions occur.

15) Study health policy options to reduce the rate of uninsurance at Small Businesses, including the creation of a Small Business Health Policy Committee to assist small employers secure health insurance, allowing very small employers to obtain health insurance and making health insurance more affordable for small businesses and employees to expand affordable commercial insurance.

Purpose of the Study

The purpose of this study is to examine current health policy nationally for potential small group reform approaches that could be successful at reducing the rate of uninsurance for small employers in Kansas. In collaboration with the Small Business Health Insurance Steering Committee and the Kansas Health Policy Authority, schramm^oraleigh Health Strategy (srHS) examined the issues critical to small employers in Kansas. We examined the small employer health insurance market from the perspective of the key players in the market:

- Regulator
- Employer
- Employee
- Carrier

Based on that review, srHS examined potential strategies used nationally to increase the insurance rate in the small employer market and their applicability to Kansas.

Small Employer Health Reform Experience Nationally

The issue of uninsurance at small employers is not unique to Kansas. Over the past decade, States have been deliberated and implemented a wide range of health insurance reforms the small employer health insurance market. Their reforms have typically covered four major areas:

1. Regulation – Review Small Group Insurance Market Laws and/or Structure
 - a. Laws - Rating Bands, Community Rating
 - b. Administration – Connector/Exchange
2. Affordability – Improve thru Targeted Intervention
 - a. Stability – Reinsurance, Hi-Risk Pools
 - b. Funding – Tax Credits, Subsidized Reinsurance
3. Plan Design – Develop Targeted Products
 - a. Benefits – Change Benefits Structure (Mini-Med/HSA)
 - b. Populations – Young Adult Populations/Plans (YAPs)
4. Education/Outreach
 - a. Communications Strategy – Information on Market/Reform

Options Modeled for Kansas

As a result of the Steering Committee process, srHS modeled multiple potential approaches to addressing the problem of uninsurance at Kansas' small employers:

- Administration – modeling and results described below
- Reinsurance Options – *see 11/18/08 KHPA Board presentation*
- Benefits Changes – *see 11/18/08 KHPA Board presentation*
- Population Specific Plan Design – *see 11/18/08 KHPA presentation*

Administrative Reform for Kansas

As part of this study, we examined the existing Kansas statutes governing the small employer insurance market and previous attempts to reform the small employer health insurance market in Kansas. In a notable previous move to address uninsurance in the small employer market in Kansas, the Legislature created the Business Health Partnership. As an existing statutory vehicle, the Partnership, could provide a ready vehicle for any reform efforts and potentially shorten the time to implementation for any reform proposals.

The Business Health Partnership

The Business Health Partnership (BHP) does offer stakeholders an existing legislative vehicle that could support several of the proposed reforms in the small group market without change; however some of the propositions do require amendments to the current statute.

As noted by the stakeholders, it would be desirable to utilize the BHP as a vehicle allowing multiple employers and funding sources to contribute to an employee's health insurance costs. The BHP is currently authorized to combine funds from the federal government and the state, with contributions from employers and their employees to purchase health insurance. In addition to being authorized to accept funds, the BHP also has the ability to offer Mini-Med policies, and it would not be subject to all of the health insurance benefit mandates in Kansas, however there are mandates in the BHP legislation that mandate preventive and screening services, which must be included in any policy offered.

Potential Changes to BHP Statute

There are some slight changes needed if the BHP were to offer the Mini-Med policy as currently proposed.

- The Mini-Med proposal includes a 6-month "go-bare" provision, essentially stating to be eligible for enrollment one would have had been without insurance for the previous 6 months. In the statute the BHP cannot offer its products to any business that has offered health insurance, or contributed to the cost of coverage for its employees for the previous 2 years.
- The second area of difference between proposed policy and current statute regards what is considered a full-time employee in order to be eligible for policies offered by the BHP. While the statute currently requires an employee work at least 30 hours per week to be eligible for coverage, the Mini-Med proposal requires only 20 hours per week, to allow workers who may work part time at two or more jobs to still have the opportunity to participate.

Potential Additional Roles of the BHP

In addition to offering health insurance policies to small employers, the BHP has the potential to serve multiple purposes in serving the small group market.

The BHP can take an active role in product design, ensuring quality affordable products for small employers. There are many components to this role, such as developing benefits and pricing for new products, and the development, marketing, and evaluation of RFP's for carriers to provide pricing on BHP products. The BHP could also develop service specifications for Section 125 vendors, and facilitate the development, marketing, and evaluation of RFP's for Section 125 services.

In an administrative capacity the BHP could act as a resource for small employers purchasing health insurance, regardless if the policy being purchased is offered by the BHP or not. In this situation the BHP would provide a Seal of Approval for certain products and carriers they have deemed quality affordable insurance products, as well as play a similar role as it relates to Section 125 services. The BHP could also coordinate the receipt and distribution of money from different funding sources on the employer's behalf.

Feedback and Recommendations

There are numerous potential approaches that Kansas could consider to reform the small employer health insurance market in Kansas. The BHP as it is currently written into statute is able to facilitate most of the reform proposals for the small group market, being able to offer insurance products and combine subsidies from state and federal funding sources. However, there may need to be changes made to the statute concerning the eligibility requirements for employers and employees that would more closely align with the goals of the reform proposals considered. These changes were generally favored by the stakeholders that participated in the Small Business Health Insurance Steering Committee. Additionally, potential regulatory roles of the BHP would have to be examined much more closely to ensure there is no overlap with the proposed duties and those currently being performed by other state agencies.

Report of the Physician Workforce and Accreditation Task Force to the 2009 Kansas Legislature

CHAIRPERSON: Representative Brenda Landwehr

VICE-CHAIRPERSON: Senator Vicki Schmidt

OTHER MEMBERS: Senator Laura Kelly and Representative Raj Goyle

NON-LEGISLATIVE MEMBERS: Dr. Andy Allison, Mr. Kevin Conlin, Dr. Glendon Cox, Ms. Jill Docking, Dr. Garold Minns, Dr. Robert Moser, Mr. Hugh Tappan, Mr. Scott Taylor, and Dr. Linda Warren

STUDY TOPICS

The Task Force is to study and adopt recommendations regarding physician work force accreditation issues, including:

- How best to maintain accreditation of graduate medical education programs sponsored by the University of Kansas School of Medicine in Kansas City and Wichita, with special attention to maintaining existing partnerships with Via Christi Regional Medical Center, Wesley Medical Center, and University of Kansas Medical Center-Wichita;
- Recommendations for the necessary and appropriate level of funding for graduate medical education sponsored by the University of Kansas;
- Alternative means of obtaining such funding; and
- A strategic plan to accomplish such matters.

Physician Workforce and Accreditation Task Force

REPORT

CONCLUSIONS AND RECOMMENDATIONS:

The Physician Workforce and Accreditation Task Force concluded that maintaining and expanding the current physician workforce capacity is vital to the health of the state's citizens. The state's Graduate Medical Education Program is a major component in meeting the demand for physicians, particularly in the specialty areas of family medicine, internal medicine, and pediatrics and particularly in underserved areas of the state. An adequately funded GME Program also is one of the best retention tools the state can employ. Additionally, meeting the increasing demand for physician services will have a beneficial impact on the economy of the communities the physicians serve.

The Task Force concluded that federal and state funding for the state's GME Program is being reduced at a time when the demand for physicians in the state is increasing. Without a dedicated funding stream, the GME Program will lose its ability to attract residents into the Program, to attract and retain qualified paid and volunteer faculty, will increase its risk of losing accreditation for the various residency programs, and will have greater difficulty in retaining physicians to serve in Kansas. Further, without a dedicated funding stream, planning and budgeting for any expansion in the GME Program becomes extremely difficult and significantly reduces the ability to successfully expand the Program and to increase the physician workforce in Kansas.

The Task Force further concluded that there is a need for better communication between the Kansas City and Wichita residency programs and that the state's GME Program must establish a "one voice" policy that fairly and equitably recognizes and supports the differences in the two programs. To better ensure sufficient funding for both programs, the two campuses must establish an accounting protocol that allows an accurate comparison of the programs and, at the same time, identifies funding deficiencies and unmet programmatic needs of each program.

Therefore, the Physician Workforce and Accreditation Task Force makes the following recommendations to the 2009 Legislature:

- That, for FY 2009, the Legislature not reduce the \$2.5 million appropriation provided to the Wichita Center for Graduate Medical Education program;
- That, for FY 2010, the Legislature include an appropriation proviso to increase funding for the Wichita Center of Graduate Medical Education program by \$6.5 million and to increase funding for the Kansas University School of Medicine GME program by \$1.4 million to help offset a portion of the losses the programs are experiencing and to better ensure the continued participation of the various hospitals in the state's GME Program; and

- That, for FY 2010, and subsequent fiscal years, the Legislature consider alternative, sustainable funding sources for the state's GME Program to help offset the losses in federal GME funding. Possible funding sources could include medically related NAICS codes such as specialty hospitals and freestanding ambulatory surgical and emergency centers.

The Physician Workforce and Accreditation Task Force also recommends that further attention and resources be provided by the Legislature in the following areas:

- Continued work with the state's Congressional delegation and with the Obama administration to modify federal restrictions on GME funding and to increase the number of resident positions supported nationally;
- Continued efforts to identify ways to increase existing funding sources such as Medicare and Medicaid and to identify alternative funding sources to support the state's GME program;
- Continued efforts to identify ways to improve the quality, accuracy and timeliness of physician workforce capacity data and to offer guidance to the various state agencies and organizations who participate in the collection of the data;
- Continued efforts to develop a single set of recommendations to drive a statewide strategy to address workforce shortages, including the continuation and possible modeling of such projects as the Kansas Primary Care Collaborative. As a better means of collecting current and accurate physician workforce is developed, including the identification of actual physician need by specialty, support should be focused on those programs currently fulfilling the mission of training physicians for Kansas; and
- Continued review of the current structure of Graduate Medical Education in Kansas to determine the most optimal structure to accommodate the growing importance of the Graduate Medical Education Program to the state.

Proposed Legislation:

None.

BACKGROUND

The Physician Workforce and Accreditation Task Force was created by language included in the Health Care Reform Act of 2008 (House Sub. for SB 81). As set out in the legislation, the Task Force is composed of thirteen members:

- *Appointments by the Dean of the School of Medicine of the University of Kansas Medical Center* - two members who are medical

faculty or administrators of the School of Medicine of the University of Kansas Medical Center, of which one member shall be from the Kansas City campus and one member shall be from the Wichita campus;

- *Appointments by the Governor* - two members who practice medicine in Kansas and are current or former participants in a Kansas graduate medical residency program;

- *State Board of Regents* - one member;
- *Wichita Center for Graduate Medical Education Governing Body* - one member who is a representative of the Via Christi Regional Medical Center and one member who is a representative of the Wesley Medical Center;
- *Kansas Health Policy Authority* - one member;
- *Kansas Hospital Association* - one member who is an administrator at a rural hospital; and
- *Legislature* - one legislative member appointed by the President of the Senate, one legislative member appointed by the Speaker of the House of Representatives, one legislative member appointed by the Senate Minority Leader, and one legislative member appointed by the House Minority Leader.

The Speaker of the House of Representatives designates one Task Force member to serve as Chairperson and the President of the Senate designates one Task Force member to serve as Vice-Chairperson. The Task Force meets on the call of the Chairperson or on the request of seven members, subject to approval by the Legislative Coordinating Council.

The Task Force is charged with studying and adopting recommendations for the following physician workforce and accreditation issues:

- How best to maintain accreditation of graduate medical education programs sponsored by the University of Kansas School of Medicine in Kansas City and Wichita, with special attention to maintaining the existing partnerships with Via Christi Regional Medical Center, Wesley Medical Center and the University of Kansas Medical Center - Wichita;

- Recommendations for the necessary and appropriate level of funding for graduate medical education sponsored by the University of Kansas;
- Alternative means of obtaining such funding; and
- A strategic plan to accomplish such matters.

The Task Force is to report its findings and recommendations to the Senate Committee on Ways and Means and the House Committee on Appropriations prior to the beginning of the 2009 Legislative Session.

COMMITTEE ACTIVITIES

The Physician Workforce and Accreditation Task Force met four times for a total of five days to study the topics outlined in the Task Force's statutory charge. The meetings were held at the KU School of Medicine-Wichita, the Chang Clinic (Wichita), the campus of Wichita State University, and at the Statehouse in Topeka. The deliberations of the Task Force are summarized below.

Graduate Medical Education in Kansas

Task Force members were provided testimony detailing the structure of graduate medical education (GME) programs in Kansas. Medical graduates seeking to complete their required residency program within Kansas are able to participate, if accepted, in one of two programs: a residency at the Kansas University School of Medicine (KU SOM) or a residency at the Kansas University School of Medicine-Wichita (KU SOM-Wichita). The University of Kansas is the academic sponsor of both GME programs and both are accredited by the Accreditation Council for Graduate Medical Education (ACGME).

Within these similarities, the Task Force heard testimony from university officials

explaining important differences between the two programs. The two programs use different models in their training of residents. The KU SOM was created in 1905. Kansas City's program operates under an academic medical center model with a predominantly full-time faculty that spends significant time both teaching and practicing medicine. There are 394 full-time and 54 part-time clinical faculty and 821 volunteer clinical faculty.

The GME program in Wichita, created by the Legislature in 1971, uses a community-based model with a smaller number of full and part-time faculty and a predominantly volunteer faculty. The Wichita program, when established as an education site, was specifically prohibited from developing research as a significant theme. The Wichita program has 58 full-time and 74 part-time clinical faculty and 1,003 volunteer faculty to assist in educating residents.

In Kansas City, the School of Medicine has partnered with The University of Kansas Hospital and the Kansas University Physicians, Inc. (KUPI). The Wichita program operates through a consortium, the Wichita Center for Graduate Medical Education (WCGME), which includes the KU School of Medicine-Wichita, Wesley Medical Center and Via Christi Regional Medical Center. The consortium was established to employ resident physicians; coordinate the graduate medical education programs across the member institutions, provide a means of standardizing payroll and financial processes across hospitals, and access more favorable state-sponsored liability insurance for residents.

WCGME partners with the KU School of Medicine-Wichita Medical Practice Association (MPA). In addition, WCGME partners with the Smoky Hill Family Medicine Residency Program in Salina. In 1977, the Legislature, recognizing the physician workforce shortage, encouraged an affiliation agreement between Kansas hospitals and the KU School of Medicine-Wichita to develop residency programs in an

area not currently providing training. As a result, the Smoky Hill Family Medicine Residency Program was established in Salina. Smoky Hill is the only fully accredited residency program located outside of Wichita or Kansas City.

Another key difference between the programs relates to how the employment of residents is categorized. Residents in Kansas City are employees of the State of Kansas. Residents in Wichita are employed by WCGME, and residents in Salina are paid by the Salina Health Education Foundation. In 2008, the Kansas City program included 456 residents/fellows in 43 programs at 30 different locations. The Wichita program had 275 residents/fellows in 14 programs training at 109 different locations.

A major focus of the Task Force meetings was an examination of the differences that exist in the way revenues and expenditures are accounted for between the Kansas City and Wichita residency programs. While each program provided its individual revenues and expenses, it was routinely noted by university officials that a true comparison of the two programs' finances would be difficult since each uses a different method for allocating its respective funds. The Kansas City program, for example, does not separate out the faculty time costs for GME. Instead, faculty are paid a base salary which includes both time spent teaching and clinical responsibilities.

Residency Program Accreditation

The Task Force heard testimony on the accreditation status of Kansas City and Wichita residency programs. Officials of the Kansas City program stated that, in 2004 - 2008 time period, the General Surgery, Neurological Surgery and Obstetrics and Gynecology residency programs were on probation for limited periods of time but all now have received continued accreditation. Common GME program citations in Kansas City included documentation of cases and work hours; sufficient number of cases of specified types; lack of scholarly activity; and the type

of faculty subspecialists and experiences. The Otolaryngology residency program received a commendation from ACGME.

Officials of the Wichita program stated that none of the WCGME programs have been on probation. Common GME program citations included documentation, faculty subspecialists, scholarly activity and research, and resident support services. The WCGME program has received commendations for six of its residency programs and has received one institution commendation. WCGME officials further stated that the change in ACGME accreditation standards which are mandating protected time for faculty research, teaching and administration, accompanied with reduced Medicare GME funding, have created a funding issue for the WCGME program.

Additionally, the Task Force heard testimony concerning possible research partnership opportunities with private industry in the Wichita area as a means of meeting the increased emphasis on medical research that is being communicated by ACGME. The Task Force toured the National Institute for Aviation Research (NIAR) facility, one example of a medical research partnership.

Funding for the Kansas City and Wichita Programs

The Task Force heard testimony from officials of the Kansas City and Wichita programs on the funding of their respective programs. In FY 2009, the Kansas City program projects that it will generate approximately \$142 million from various revenue and funding sources. Of the \$142 million, approximately \$10 million is projected to come from the State General Fund or other state support and approximately \$6.7 million is projected to come from Medicare GME. Approximately \$84 million in funding and revenue is shown in a single “All Other Funds” category that includes items such as faculty and resident professional fee collections, state and foundation faculty support, and ancillary

collections. The Kansas City program projects approximately \$142 million in total expenditures, with no projected net loss in FY 2009.

In FY 2009, the Wichita program, including Salina, projects that it will generate approximately \$60 million from various revenue and funding sources. Of the \$60 million, approximately \$6.6 million is projected to come from the State General Fund and other state support, \$23.6 million from Medicare GME and \$8.9 million from Medicaid GME. Approximately \$17.1 million is projected to come from the “All Other Funds” category. Included in the projected income is \$3,190,000 in funding from the Kansas Bioscience Authority (KBA). Of the total projected KBA funding, \$150,000 had been received in December 2008. The Wichita program projects approximately \$60 million in total expenditures, with a projected net loss of \$6.4 million.

Status of Additional FY 2009 WCGME Funding. WCGME received an additional \$2.5 million appropriation from the State of Kansas for FY 2009. Of the \$2.5 million, \$1.5 million was appropriated with the condition that WCGME request a \$7.1 million research-oriented grant from the KBA. The language included in House Sub. for SB 81 stated that the \$7.1 million grant was to be expended for the purposes of funding non-research needs such as offsite or rural rotations for which Medicare funding had been terminated or for purposes of attaining adequate standards for accreditation of the WCGME residency programs.

WCGME provided testimony showing the allocation of the \$2.5 million received from the State of Kansas. Approximately \$1.1 million is allocated to replace recently reduced Medicare GME reimbursement for resident off-site monthly rotations and resident educational leave and non-clinical educational experiences. Approximately \$960,000 is allocated for faculty salaries and benefits to provide for the increase in time that will be required to meet the ACGME mandated requirement for protected time for

faculty research, teaching and administration. WCGME also has allocated \$100,000 to provide electronic health record capability for the Family Medicine Clinic which is now a requirement for the Family Medicine residency program.

The Task Force heard testimony concerning the KBA grant application which included a synopsis of the grant process. It stated that in August 2008, after the initial WCGME proposal was submitted to the KBA, the Executive Vice Chancellor/Executive Dean of the KU School of Medicine was directed by the KBA to submit a different proposal. The new proposal called for \$2.9 million funding for the first year and would establish three research-related centers. In September 2008, the KBA Board of Directors provided \$250,000 to fund a study to develop a strategic plan addressing the research issues and need for sustained funding of the WCGME program. In October 2008, the KBA Board of Directors took action to fund the first year at \$2.9 million, with the possibility of second year funding of \$1.9 million and third year funding of \$0.9 million. Resubmissions of the grant application will have to be made for the second and third years and KBA formularies will have to be met to receive the remainder of the \$7.1 million grant. In January 2009, the strategic study was in process and the contract for the \$2.9 million grant was under discussion between the WCGME staff and KBA staff.

Funding Shortfalls of WCGME Hospitals.

Task Force members heard testimony detailing the ongoing funding shortfalls faced by Via Christi Health System and Wesley Medical Center due to their participation in GME. An official representing Wesley Medical Center stated that the hospital lost \$1.062 million in FY 2007 as a result of the shortfall. Additionally, an official representing Via Christi Health System stated that the hospital lost \$2.552 million in FY 2007 due to the lack of funding. The Task Force members were informed by representatives of each hospital that, unless additional funding is made available, Via Christi and Wesley are no

longer able to subsidize the shortfall in GME funding and will not be able to fund GME costs in excess of those reimbursed by Medicare and Medicaid.

WCGME Proposal for FY 2010 Funding.

A WCGME representative provided the Task Force with a breakout of the funding needs for the WCGME program in FY 2010 to meet the funding shortfall of the WCGME program. WCGME projected a total funding need of \$6.5 million. Of that amount, \$2.5 million is to be used to sustain the \$2.5 million received in FY 2008. The funds would be used to recruit and retain faculty, to meet accreditation standards requirements, (including scholarly research activities and protected and supervisory time for faculty), and for the recruitment and retention efforts for primary care physicians. Another \$1.0 million is to be used to offset the loss of Medicare GME reimbursement for resident physicians who are training in offsite and rural locations. The remaining \$3.0 million is to be used to offset the loss to the two consortia hospitals, Via Christi Health System and Wesley Medical Center, resulting from the loss of Medicare GME reimbursement. The WCGME representative further noted that it is unlikely that the grant funding received from KBA can be used to meet this funding need because the KBA funds are targeted specifically for research efforts and not education efforts.

Physician Workforce Capacity

The Task Force heard testimony concerning the adequacy of the physician workforce to meet the state's needs. As part of the larger discussion on physician workforce issues, members heard testimony on the 2007 Kansas Physician Workforce Report, a joint effort of the University of Kansas School of Medicine, the Kansas Academy of Family Physicians, and the Kansas Department of Health and Environment. Task Force members heard that the number of residency slots in Kansas is below the national average. Kansas has 731 residency slots, or

27/100,000 Kansans, as compared to the national average of 34.3/100,000. It also was noted that there is an alarming shortage of physicians in rural communities nationwide and that Kansas is currently below the national average for physicians per 100,000 population. Kansas has 203 physicians/100,000 as compared to the national average of 246 physicians/100,000 population. Kansas has a mal-distribution of physicians, with Southeast and Southwest Kansas the most underserved areas. Additionally, other states are expanding educational and practice opportunities as a result of anticipated physician shortages and, as a result, Kansas will likely lag behind due to increased out-migration of medical school graduates and residents.

The Task Force heard testimony concerning the Kansas Primary Care Collaborative (KPCC) which was formed by the KU Schools of Medicine in Wichita and Kansas City to study and promote the importance of primary care education and practice. Since the initial meetings of the Collaborative, KPCC members have formed subcommittees to accomplish the goal of increasing the number of primary care physicians practicing in Kansas. The KPCC is working toward submitting reports and recommendations to the Deans of each School of Medicine on how to best proceed on the primary care issue.

The Task Force heard testimony on the physician retention efforts underway in Kansas including the Kansas Recruitment Center, the Kansas Locum Tenens program, the Kansas Medical Resource program, and the Kansas Bridging Plan. Testimony concerning the physician retention rates of the Kansas City and Wichita programs showed that for the Kansas City program, of the 552 residents who finished in the last five years, 48 percent stayed in Kansas. Of the 67 primary care residents who did all their training in Kansas, 81 percent practice in Kansas. For the Wichita program, of the 334 graduates between 2004 - 2008, 52 percent are practicing in Kansas. Of the 211 graduating primary care residents which includes family medicine,

internal medicine, medicine and pediatrics, and pediatrics, 63 percent are practicing in Kansas.

Throughout the testimony on Kansas' physician workforce shortage, conferees noted that, at the present time, there is no single collection process or point for gathering data on the state's physician workforce. The data shortage applies to information on where physicians are practicing geographically, their types of practice, and other basic demographic data. In response to the lack of available information, multiple Task Force members stressed the importance of remedying the problem in order to better understand the workforce shortage.

Impact of Reduced Funding on the Kansas GME Program

Task Force members also heard testimony identifying the benefits to Kansas and to local communities from having residency programs and the impact of not having the programs. Multiple conferees stated that one of the most important benefits is that the programs train and attract new physicians for Kansas, including rural areas of the state. Testimony provided by the School of Medicine stated that with residents, both teaching hospitals and communities possess the ability to have 24-hour on call coverage, increased capacity for recruiting and retaining physicians, and to have physicians see and treat an increased number of patients. Additionally, residents provide care to thousands of uninsured and indigent patients.

It was noted that, in Wichita, residents have a positive economic impact. Within Wichita, there are 272 residents, 300 dependents, and numerous faculty members. The economic impact on the Wichita and surrounding area from the KU School of Medicine-Wichita program in 2005 was estimated to include approximately \$11.7 million in faculty salaries and benefits and approximately \$13 million in resident salaries and benefits. It also was reported that the

annual economic impact in Kansas of one family physician to a community is \$871,642.

Alternative Funding Sources

Task Force members heard testimony on alternative funding sources that would assist in providing reliable, sustainable funding for the state's GME Program. The optimal use of affiliation agreements was discussed as well as opportunities to partner with local industries in medical research endeavors and the availability of philanthropic resources. Testimony and discussion also included the possible use of some of the funding received from one of the 21 North American Industry Classification System (NAICS) codes that are used in the formula to fund the KBA; specifically, Code #622110 - General Medical and Surgical Hospitals. The Kansas Department of Labor reported that, for the first three quarters in CY 2008, the KBA received approximately \$27 million from revenue generated by the use of the NAICS code.

In addition to Code #622110, the Task Force heard testimony identifying other NAICS codes that potentially could be used for GME funding. Department of Revenue and Department of Labor officials informed the Task Force that there are codes outside of the KBA funding structure related to the medical profession. The two codes generating significant interest were #621493-Freestanding Ambulatory Surgical and Emergency Centers, and #622310-Specialty Hospitals.

Task Force members also discussed the need to identify any additional avenues to draw down more federal Medicare and Medicaid dollars. A recent example included the estimated \$8.8 million in additional Medicaid funding the Kansas Health Policy Authority was able to secure by a State Plan Amendment to the State Medicaid Plan. The funding will pay for care provided by University of Kansas faculty physicians and associated outpatient clinics in Kansas City and Wichita. The Health Policy Authority requested the change in February 2008

at the request of the KU SOM and the University of Kansas Hospital because of the high volume of Medicaid patients the physicians who teach at the School of Medicine serve and because the Medicaid reimbursement rates are below actual costs and the losses cannot be offset by higher paying patients.

Additionally, the Task Force members received testimony on several federal GME issues including the following:

- Resident FTEs reimbursed by Medicare are capped based on FY 1996 FTEs, before the physician shortage was recognized; the cap needs to be eliminated;
- Medicare currently pays GME to a teaching institution for the time spent at non-hospital settings, as long as the teaching institution pays "all or substantially all" of the costs; Congress can clarify "all or substantially all" refers to resident stipends and benefits and only the other amounts agreed to by the teaching institution and non-hospital setting;
- Medicare GME payments exclude the time residents spend in research and didactic activities, regardless of who bears the costs;
- Direct Graduate Medical Education "per resident" reimbursement is based on 1984 Medicare Cost Report information, with an annual inflation factor, which has created wide variations in national per resident amounts; and
- A proposed Medicaid rule, currently under a Congressional moratorium until April 1, 2009, would end Medicaid federal DGME payments.

The Task Force discussed the need to include physician workforce as an essential element of health reform and that federal policy must be amended to include Graduate Medical Education

as a meaningful element in health reform legislation. It further discussed the need to work with the state's Congressional delegation to clearly communicate the impact on the state of current and proposed Medicare and Medicaid policy changes.

CONCLUSIONS AND RECOMMENDATIONS

The Physician Workforce and Accreditation Task Force concluded that maintaining and expanding the current physician workforce capacity is vital to the health of the state's citizens. The state's Graduate Medical Education Program is a major component in meeting the demand for physicians, particularly in the specialty areas of family medicine, internal medicine, and pediatrics and particularly in underserved areas of the state. An adequately funded GME Program also is one of the best retention tools the state can employ. Additionally, meeting the increasing demand for physician services will have a beneficial impact on the economy of the communities the physicians serve.

The Task Force concluded that federal and state funding for the state's GME Program is being reduced at a time when the demand for physicians in the state is increasing. Without a dedicated funding stream, the GME Program will lose its ability to attract residents into the Program, to attract and retain qualified paid and volunteer faculty, will increase its risk of losing accreditation for the various residency programs, and will have greater difficulty in retaining physicians to serve in Kansas. Further, without a dedicated funding stream, planning and budgeting for any expansion in the GME Program becomes extremely difficult and significantly reduces the ability to successfully expand the Program and to increase the physician workforce in Kansas.

The Task Force further concluded that there is a need for better communication between the Kansas City and Wichita residency programs and that the state's GME Program must establish

a "one voice" policy that fairly and equitably recognizes and supports the differences in the two programs. To better ensure sufficient funding for both programs, the two campuses must establish an accounting protocol that allows an accurate comparison of the programs and, at the same time, identifies funding deficiencies and unmet programmatic needs of each program.

Therefore, the Physician Workforce and Accreditation Task Force makes the following recommendations to the 2009 Legislature:

- That, for FY 2009, the Legislature not reduce the \$2.5 million appropriation provided to the Wichita Center for Graduate Medical Education program;
- That, for FY 2010, the Legislature include an appropriation proviso to increase funding for the Wichita Center of Graduate Medical Education program by \$6.5 million and to increase funding for the Kansas University School of Medicine GME program by \$1.4 million to help offset a portion of the losses the programs are experiencing and to better ensure the continued participation of the various hospitals in the state's GME Program; and
- That, for FY 2010, and subsequent fiscal years, the Legislature consider alternative, sustainable funding sources for the state's GME Program to help offset the losses in federal GME funding. Possible funding sources could include medically related NAICS codes such as specialty hospitals and freestanding ambulatory surgical and emergency centers.

The Physician Workforce and Accreditation Task Force also recommends that further attention and resources be provided by the Legislature in the following areas:

- Continued work with the state's Congressional delegation and with the

Obama administration to modify federal restrictions on GME funding and to increase the number of resident positions supported nationally;

- Continued efforts to identify ways to increase existing funding sources such as Medicare and Medicaid and to identify alternative funding sources to support the state's GME program;
- Continued efforts to identify ways to improve the quality, accuracy and timeliness of physician workforce capacity data and to offer guidance to the various state agencies and organizations who participate in the collection of the data;
- Continued efforts to develop a single set of recommendations to drive a statewide

strategy to address workforce shortages, including the continuation and possible modeling of such projects as the Kansas Primary Care Collaborative. As a better means of collecting current and accurate physician workforce is developed, including the identification of actual physician need by specialty, support should be focused on those programs currently fulfilling the mission of training physicians for Kansas; and

- Continued review of the current structure of Graduate Medical Education in Kansas to determine the most optimal structure to accommodate the growing importance of the Graduate Medical Education Program to the state.

**Report of the Physician Workforce and
Accreditation Task Force
to the 2009 Kansas Legislature**

REPORT ADDENDUM

February 20, 2009

State of Kansas
House of Representatives

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TOPEKA

BRENDA K. LANDWEHR

Representative, Ninety-First District

COMMITTEE ASSIGNMENTS
CHAIR: HEALTH & HUMAN SERVICES
VICE CHAIR: KANSAS HEALTH POLICY OVERSIGHT
MEMBER: GOVERNMENT EFFICIENCY AND
FISCAL OVERSIGHT
JUDICIAL COUNCIL JUVENILE OFFENDER
CHILD IN NEED OF CARE ADVISORY

Kansas State Senators Vicki Schmidt and Laura Kelly, members of the Physician Workforce and Accreditation Task Force established by the 2008 Kansas Legislature, have asked that the attached letter be included as part of the Task Force's response to the 2009 Legislature. They have challenged the Task Force as a legitimate group to study and make public policy recommendations about the complicated issue of graduate medical education funding and the related need to align funding to assure that our state has an adequate physician workforce.

I believe the Task Force established by the 2008 Kansas Legislature, which was made up of representatives of the medical and medical education communities; representatives from impacted hospitals both urban and rural; as well as legislators, has clearly brought together a group of people with the expertise to study and make public policy recommendations about the issue.

Given its legislative charge, I believe that the complex issue of studying the efficacy and funding for these two models of graduate medical education appropriately rested with the task force that included membership of the medical community from across Kansas as well as representation from the Kansas Board of Regents and Kansas Health Policy Authority.

Senators Schmidt and Kelly have challenged the recommendation of the Physician Workforce and Accreditation Task Force to shift funding from the Kansas Bioscience Authority (KBA) to the KU School of Medicine as a funding source to address the graduate medical education funding needs and inequities in Kansas, stating no public testimony was received from the KBA or other public entities as to the impact of the recommendation. Senator Schmidt didn't object during the meeting and Senator Kelly wasn't present in the afternoon when the recommendations were reached.

The two Senators suggest that the charge of studying and evaluating the needs of graduate medical education in Kansas and making policy recommendations to the Kansas Legislature should be shifted to the Kansas Board of Regents. While the Board of Regents has ultimate authority over higher education in Kansas, graduate medical education is a subset that is paid for by a combination of federal funding directed through teaching hospitals and supplemental state funding. In Kansas, we have two different successful models for addressing graduate medical education. One, at the Kansas City campus of KU Medical School, relies on both the hospital funding and physicians employed as faculty by the KU Medical Center; the other at the Wichita

campus of the KU Medical Center, is directed by a consortium of the two private teaching hospitals and KU Medical center, relying on the services of over 1,000 volunteer physicians.

In closing, members of the Task Force have expressed that the Task Force facilitated the exchange of information and opened discussions with the individuals of the two programs as well as the Regents concerning this significant public policy concern. The Task Force was invited and members attended the meeting with the Congressional delegation in late January to discuss the state's concerns about the federal support of graduate medical education. The federal support was one of many ideas brought up in the Task Force meetings and the discussion with the Congressional delegation went very well. The Task Force met its charge to provide recommendations to the Legislature. There is still work to be done on a permanent funding stream for graduate medical education in Kansas as well as coming up with a solution to solve the shortage of Physicians in Kansas. The legislature will need to further the discussions and make the final decisions on funding graduate medical education for Kansas.

A handwritten signature in black ink, reading "Brenda K. Landwehr". The signature is written in a cursive style with a large, prominent initial "B".

Representative Brenda Landwehr
Chair, Physicians Task Force

STATE OF KANSAS

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SENATOR VICKI SCHMIDT
ASSISTANT MAJORITY LEADER

February 16, 2009

COMMITTEE ASSIGNMENTS

CHAIR: ETHICS AND ELECTIONS
VICE-CHAIR: PUBLIC HEALTH AND WELFARE
MEMBER: INTERSTATE COOPERATION
TRANSPORTATION
WAYS AND MEANS

JOINT COMMITTEES

CHAIR: ADMINISTRATIVE RULES
AND REGULATIONS
MEMBER: HEALTH POLICY OVERSIGHT
INFORMATION TECHNOLOGY

The Honorable Brenda Landwehr
Chairperson, Physician Workforce and Accreditation Task Force
Kansas State Legislature
Department of Kansas Legislative Research
Topeka, Kansas 66612

Dear Chairperson Landwehr,

We appreciate the opportunity to provide feedback and additional comments on the draft report of the Physician Workforce and Accreditation Task Force to the 2009 Kansas Legislature. We are offering these comments as dissenting or differing views from those embodied in the report in a variety of sections. Although we are from different political parties, we certainly see many of these issues from the same perspective and are expressing them accordingly. We are also expressing them as members of the Senate Ways and Means Committee where we have served for the previous four years, working diligently to find adequate resources for the many needs in our state.

While we have clearly learned a great deal as members of this Task Force, we do not believe that the structure of this task force best lends itself to tackling the many complicated challenges facing graduate medical education funding in our state and the best alignment of resources to increase our physician workforce. Clearly, these challenges are such that the Kansas Board of Regents in its role overseeing the KU School of Medicine in Wichita and Kansas City can and must steer this public policy.

Further, we wish to express grave concerns with the concept of shifting funding from the Kansas Bioscience Authority to the KU School of Medicine without considerable further study and analysis. This idea was only first mentioned at the very last afternoon of the last meeting of the task force in late January. We had no public testimony from the Kansas Bioscience Authority or any other entities as to the impacts such a major policy shift would have in our state. It is outlandish to suggest that this group was given adequate information to frame this option as a "recommendation" and we would take sharp exception to that notion.

Thank you for allowing us to submit this letter for inclusion in the report. We would also like to thank the outstanding staff of the Kansas Legislative Research Department for the countless hours of work they invested in this effort.

Sincerely,

Handwritten signature of Vicki Schmidt in black ink.

Senator Vicki Schmidt

Handwritten signature of Laura Kelly in black ink.

Senator Laura Kelly

The Status of Physical Fitness Among Kansas Youth

Progress through Coordinated School Health

Prepared by
Kansas Department of Health and Environment
December 2008



in response to a request for information by the
Legislative Coordinating Council

Introduction

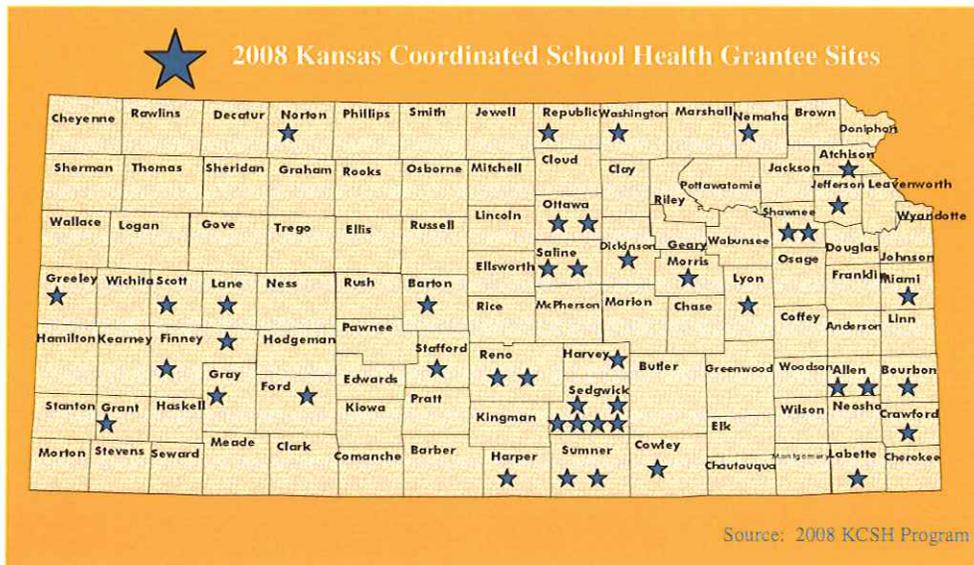
Since 1980, the national prevalence of overweight has more than doubled in children, aged 6-11 years, and tripled in adolescents, aged 12-19 years. ¹

Individuals who become overweight in childhood are more likely to become overweight as adults and are at higher risk for chronic conditions such as Type 2 diabetes and heart disease. ² Without lifestyle interventions, one in three US children born today will develop diabetes; if that child is a Hispanic female, her chances of developing diabetes in her lifetime increase to one in two. ³ Between 2002 and 2005, the prevalence of Type 2 antidiabetic prescription use among children more than doubled, with obesity as one of the key factors for development of this chronic disease. ⁴ Recently released data suggests that artery wall thickness of some obese children resembles that of the average 45-year old. ⁵ Without positive, health promoting life-style changes, number of overweight youth will continue to increase along with chronic diseases associated with excess body weight.

While these statistics are alarming and the efforts required to effect behavior change seem daunting, the 2008 state legislature responded positively by allocating funds to support the Kansas Coordinated School Health (KCSH) program.

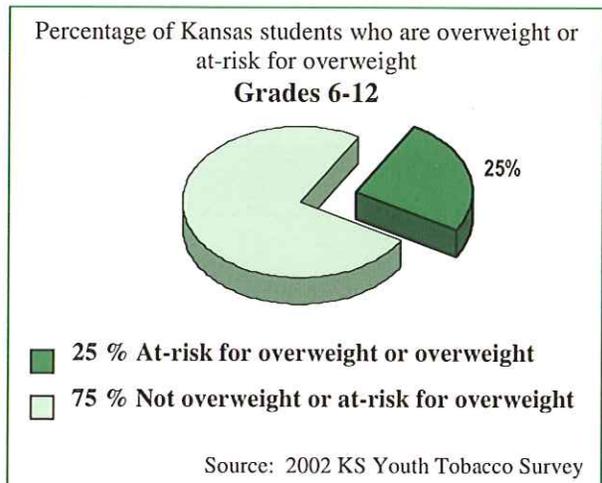
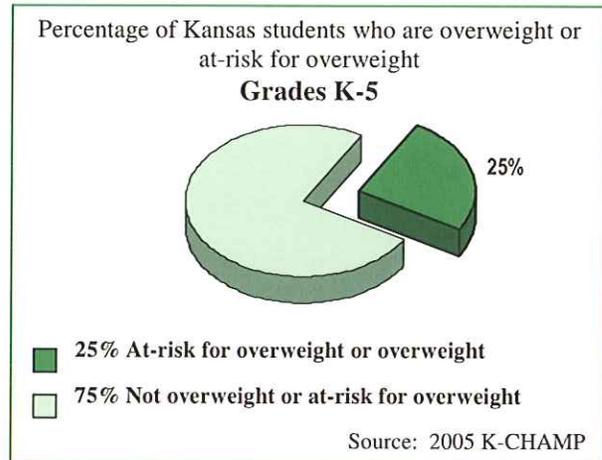
Coordinated School Health represents the only state funded initiative to reduce childhood obesity.

To address the primary risk factors for childhood obesity, in 2008 KCSH focused efforts on nutrition, nutrition education and physical activity. The Kansas School Wellness Model Policies, ⁶ initiated as a result of Kansas Senate Bill 154, ⁷ were integrated into the evidenced-based structure of KCSH to assist Kansas school districts in addressing these issues. As a result, school districts have access to funding and technical assistance required to institute changes that will impact the health and wellness of students.



State funds allocated in 2008 allowed KCSH to make substantial investments in health in over 40 school districts across the state. At a minimum, 77,000 students in 31 Kansas counties are being impacted. Minority students make up 30% of the grantee population, 13% are special education students and over 33,000 students in these districts are eligible for free or reduced lunch.⁸

Nearly 500,000 Kansas children spend as much as nine hours each day in the public school setting. This means that nearly 50% of daily energy expenditure among these children should occur while they are at school and close to one third of their total daily energy requirement should come from the lunch eaten at school.⁹ Schools should promote and implement quality nutrition and physical education curricula to meet these recommendations. KCSH assists districts in these efforts.



State & Federal Recommendations for Impacting Student Health

KCSH efforts to impact nutrition, nutrition education and physical activity are grounded in state and national recommendations developed through the Governor's Healthy Kansas initiative, Healthy People 2010 and the federal child nutrition program. With the intent of increasing quality and years of healthy life and eliminating health disparities, Healthy People was developed to serve as a roadmap for improving the health of all people in the United States. The most recent set of recommendations, Healthy People 2010 (HP2010), was released in 2000 and Kansas then adopted corresponding goals as Healthy Kansans 2010. Subsequently, the Governor's Healthy Kansas initiative focused efforts at the individual level to drive personal behaviors of Kansans to eat a healthier diet, move more and stop using tobacco. Both Healthy Kansas and Healthy Kansans 2010 benefited from a strong national push to address physical activity at all ages and included goals for increasing physical activity among both adults and adolescents.

Subsequent to the release of the HP2010 goals and recommendations, the federal government passed public law 108-265 reauthorizing the federal child nutrition program that includes school lunch and breakfast programs. This law also required local educational agencies to establish local “school wellness policies.” In 2005, the Kansas Legislature passed Senate Bill 154, which became Kansas statute 72-5128, supporting the federal requirement for developing local school wellness policies by directing the Kansas State Board of Education to “develop nutrition guidelines for all foods and beverages made available to students in Kansas public schools during the school day...”¹⁰ In developing such guidelines, the state law required particular attention be directed to providing healthful foods and beverages, physical activities and wellness education with the goals of preventing and reducing childhood obesity.

The state law also required that “when establishing the wellness policy of the school district, the board of education of each district shall take into consideration the guidelines developed by the state board...” To assist schools in meeting the requirements set forth by the legislature, the Kansas State Department of Education teamed with KDHE, numerous content professionals and other state partners to develop the Kansas School Wellness Policy Model Guidelines.¹¹ These guidelines became the backbone of KCSH grants to schools.

The guidelines required by KSA 72-5128 included a focus on:

- Nutrition
- Nutrition Education
- Physical Activity

Trainings were conducted across the state for school district personnel on using the model guidelines to craft local district policies. School districts were encouraged to develop a school health council consisting of district staff, parents and community partners to help guide the development of the wellness policies. Each district was required to submit their local wellness policies by July of 2006. Thereafter, districts are required to annually report progress in implementing policies.

**Kansas Coordinated School Health:
A Recognized National Leader**

- Kansas is recognized as the only state that has enacted ongoing monitoring of school wellness policies¹²
- Kansas leads the way in integrating state wellness policies with the coordinated school health model
- Kansas' work to develop a more effective model in bringing together school, community and state partners has been showcased at the 2007 American School Health Association annual conference and the 2008 American Public Health Association annual conference

2008-2009 KCSH Physical Activity Guidelines*

Basic Physical Education/Activity	Advanced Physical Education/Activity	Exemplary Physical Education/Activity
1. School district offers opportunities for 100-150 minutes of physical education (PE)/physical activity (PA) or equivalent per week	1. School district offers opportunities for 150-200 minutes of PE/PA or equivalent per week	1. School district offers opportunities for 200 + minutes of PE/PA or equivalent per week
2. School district offers 20 + minutes of recess per day for all elementary students	2. School district offers 15 + minute recess periods per day for all elementary students	2. School district offers two 15 + minute recess periods per day, with one prior to lunch, in each elementary school
3. School district will distribute educational material focused on PA to families of students at least 3 times per year	3. School district will distribute educational material focused on PA to families of students at least 3 times per year	3. School district will distribute educational materials focused on PA to families of students at least 3 times per year
4. School district will collect, record and send to the state the height and weight of all 4 th grade students	4. School district will provide extracurricular programs, clubs and intramurals that incorporate PA	4. School district will provide extracurricular programs, clubs and intramurals that incorporate PA
	5. School district will collect, record and send to the state the height and weight of all 4 th and 7 th grade students	5. School district are required to report how PA is being incorporated in other subject areas within the districts other than PE
	6. School district will collect, record and send to the state fitness level indicators related to aerobic capacity on all 4 th and 7 th grade students	6. School district will implement a walk and bike program at school
		7. School district will allow community access to activity facilities, resources/equipment to promote healthy behaviors of community residents
		8. School district will collect, record and send to the state the height and weight of all 4 th , 7 th and 9 th grade students

Developing wellness policies was a promising first step for school districts in their efforts to address student health in a comprehensive manner. Since that time, the challenge for school districts is moving from a basic level of implementation to an advanced or exemplary level. In the absence of funding to support a framework for implementing wellness strategies, school districts have experienced minimal advancement in physical activity policies.

*In addition to Physical activity, model guidelines have been written to address nutrition services, nutrition education and tobacco use prevention.

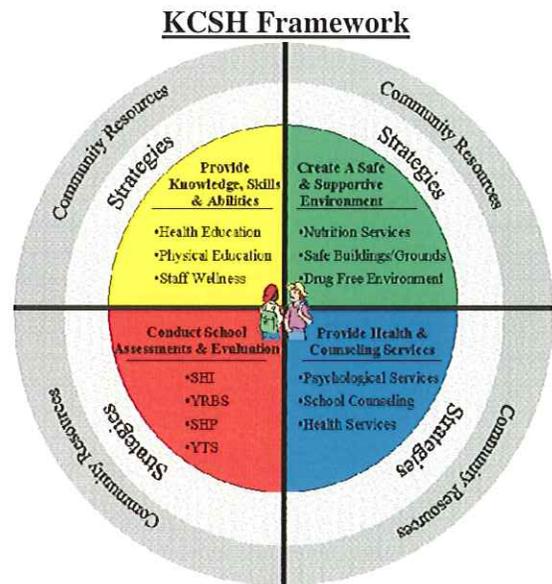
Kansas Coordinated School Health

Starting in 2003, the Kansas Department of Health and Environment (KDHE) and the Kansas State Department of Education (KSDE) collaborated to implement Kansas Coordinated School Health (KCSH) with grant funding from the Centers for Disease Control and Prevention (CDC). KCSH was established to bring state and community partners together. Each of these partners must make inroads in their own environments to complement and sustain any change that may occur at the school level.

As schools completed development of wellness policies and recognized the need to address issues of physical activity, obesity, nutrition and associated health risks, they have subsequently embarked on efforts to improve outcomes, which include new opportunities for physical activity. For many districts these new efforts have been facilitated by guidance and technical assistance from KCSH.

KCSH utilizes the CDC 8-component model: health education, physical education, health services, nutrition services, counseling, healthy school environment, health promotion for staff and family and community involvement. Kansas has focused its efforts on the model's primary tenant of obesity prevention emphasizing increased physical activity and improved nutrition practices among students, school staff and parents.

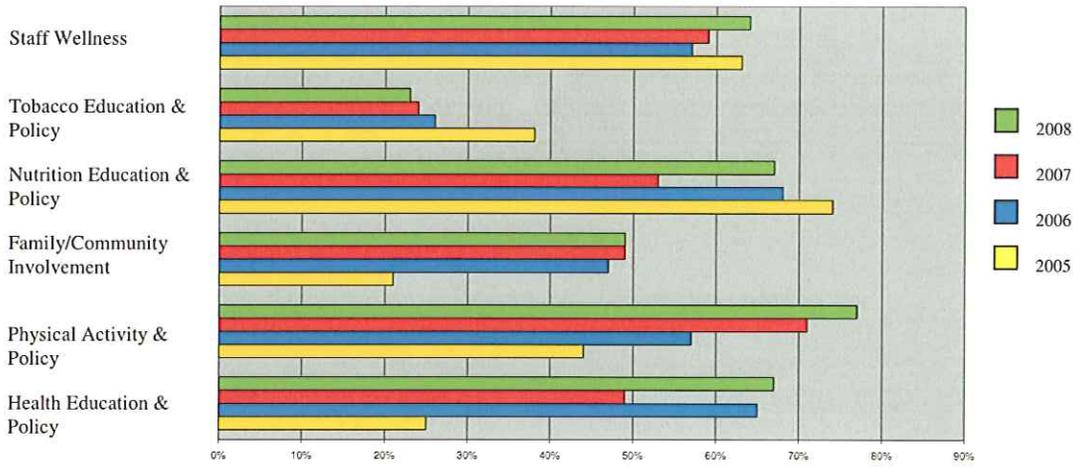
Schools continue to be a pivotal partner in every community where children can be reached with education, role-modeling and opportunities to develop the best possible knowledge, practice and attitudes about nutrition and physical activity. Continued investment in KCSH will provide the most comprehensive strategy for impacting the health of Kansas children.



™Kansas Coordinated School Health

Kansas schools that have adopted the KCSH framework have enhanced physical activity by developing PE and health curricula that align with state and national standards, tools and trainings to enhance physical activity in classrooms, and physical activity events that bring community members, families and students together, such as walking clubs and walking tracks on school grounds.

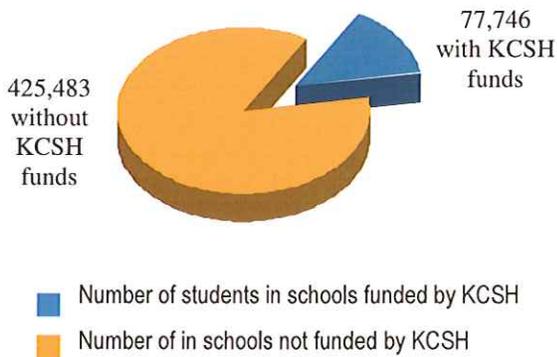
**Areas of Focus for Kansas Coordinated School Health Grantees
SFY 2005-2008**



Source: 2008 KCSH Program

In SFY 2009, inadequate resources caused KCSH to deny funding requests from four school districts that were eager to join the program. Additionally, KCSH funding awards to many very qualified districts were reduced to stay within available resources. Currently, these KCSH districts are receiving an average of \$3.50 per student to develop and implement programs that have the potential to impact health and wellness behaviors of Kansas children.¹³ In return, grantees commit to strengthening their district wellness policies in the areas of physical activity, nutrition and tobacco use prevention.

**Students impacted through
Kansas Coordinated School Health in
SFY 2009**



Source: 2008 KCSH Program

**KCSH funded school districts are
making a difference in SFY 2009**

- Funded school districts offer an average of 9 hours of nutrition education per student.
- Over 77,000 families in funded districts will receive nutrition, physical activity and tobacco use prevention educational materials.
- Students in 65% of funded school districts will exceed the number of minutes of physical activity recommended during the school day.
- Height, weight and selected physical fitness indicators will be collected by KCSH funded school districts on over 10,000 students.
- 65% of funded school districts will protect students, staff and visitors with a comprehensive tobacco-free school grounds policy.

Kansas Adolescent Health Data

KCSH draws from a wide range of data sources regarding obesity, physical activity and nutrition to help paint a picture of student health to assist in its planning and evaluation efforts. Data from student surveys, which are self-reported, such as the Kansas Youth Risk Behavior Survey (YRBS), the Kansas Youth Tobacco Survey (YTS) and special studies such as the Kansas Child Health Assessment Project (K-CHAMP) and the Kansas Nutrition, Physical Education and Physical Activity Policies and Practices project serve as baseline measures for adolescent health in Kansas.

The Kansas Nutrition, Physical Education, Physical Activity, Policies and Practices survey was administered in 2006 by the Kansas State Department of Education in partnership with the Kansas Health Institute as a result of Kansas Concurrent Resolution 1604.¹⁴ The survey was conducted in an effort to better understand the health environment for Kansas youth by examining key policies and practices that affect public school children across the state.

Key findings from the Kansas Nutrition, Physical Education and Physical Activity Policies and Practices Survey

1. Required physical education decreases at the same time vending machine items and a la carte offerings become increasingly common in school, between grades 6 and 9.
2. Physical education professionals think they need more time with children to do their jobs and instill healthy patterns of physical activity in every child.
3. Relatively few KS schools have instituted nationally recommended strategies to increase physical activity among students.

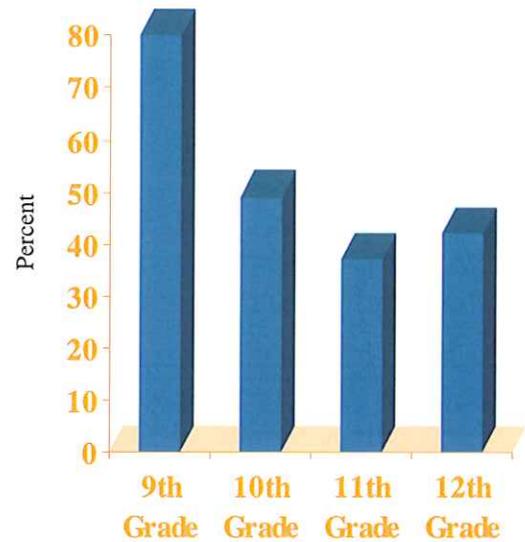
Source: Kansas Health Institute

The K-CHAMP project was conducted from 2003-2008. This project represented the most comprehensive collection of clinical height and weight data ever conducted in Kansas. KCSH utilizes the height and weight collection protocol developed for K-CHAMP. In addition to collecting height and weight data, K-CHAMP surveyed students' physical activity and nutrition habits. Student data from the survey was then correlated with appropriate height and weight data to produce a snapshot of health. The final phase of the project involved 15 focus groups conducted with parents, guardians, school administrators, teachers, youth service organizations and medical providers from across Kansas on the issue of childhood obesity.¹⁵ Preliminary analysis of the data suggests that focus group participants recognize childhood obesity as a serious health problem and feel the school setting should play a significant role in the solution. Additionally, parents supported schools' efforts to collect height and weight information as long as the information was used to guide needed change to the school environment. These findings are consistent with results from the 2005 Kansas Behavioral Risk Factor Surveillance Survey (BRFSS), a survey of Kansas adults, which indicated that nearly 75% favored collecting height and weight measurements in Kansas schools.

Current Requirements and National Physical Activity Recommendations

Kansas does not have a statewide physical education requirement for all public school students, nor does the state require a minimum number of minutes of physical activity during school. Current requirements apply to elementary students in grades K-5, do not cover students in grades 6, 7 and 8 and mandate only one unit of physical education for grades 9-12, of which one-half unit may include health education. Data collected through KCSH indicates that the majority of students in grades 9-12 fulfill the requirement during the 9th grade year, meaning the percent of students participating in physical education class in grades 10, 11 and 12 is greatly reduced.^{16, 17} In an effort to fortify physical education in Kansas schools, in 1998, a Kansas physical education curriculum guide was developed based upon the National Association for Sport and Physical Education (NASPE) National Standards for Physical Education.¹⁸

Percentage of students attending physical education (PE) classes on one or more days per week when in school



Source: 2007 Kansas Youth Risk Behavior Survey- self reported

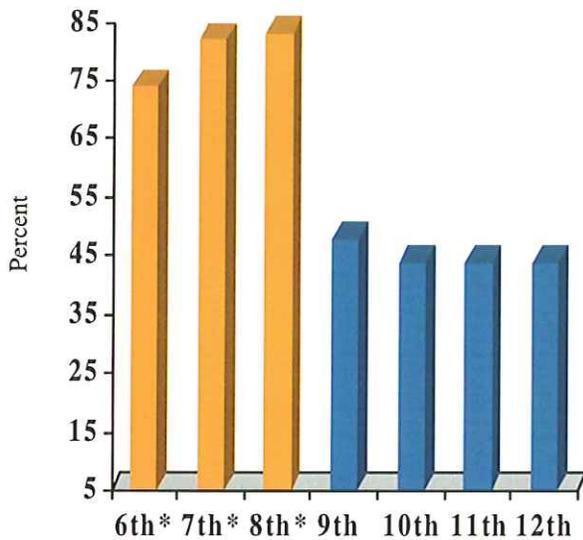
In 2008 the U.S. Department of Health and Human Services released physical activity guidelines for Americans that recommend children and adolescents engage in at least 60 minutes of moderate to vigorous aerobic physical activity daily. Because students spend nearly half of their day in school, to meet this recommendation, students should be physically active for at least 300 minutes during a five day school week or 30 minutes per day while in school.¹⁹ Guidelines developed by KCSH require schools to implement programs that will provide each student the opportunity to meet this recommendation.

By 2010, increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion to

85%

Source: Healthy People 2010

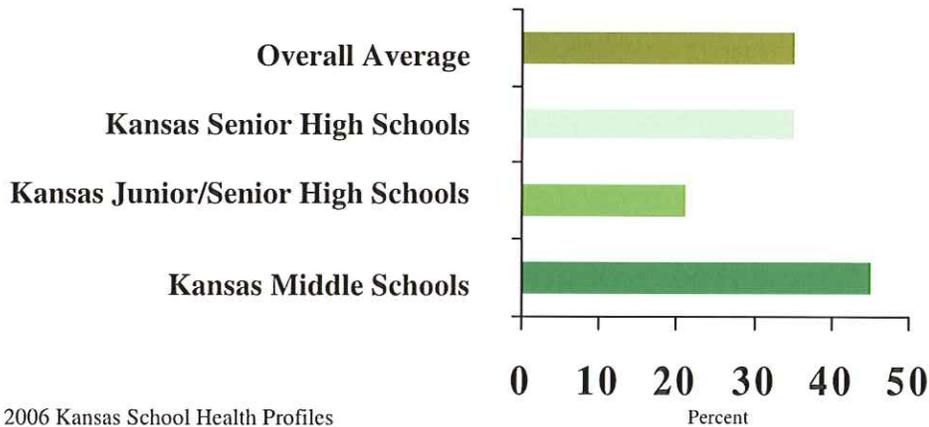
Percentage of Kansas students who were physically active for a total of at least 60 minutes per day on five or more of the past seven days



Source*: 2008 Kansas Youth Tobacco Survey- self-reported
 Source: 2007 Kansas Youth Risk Behavior Survey- self-reported

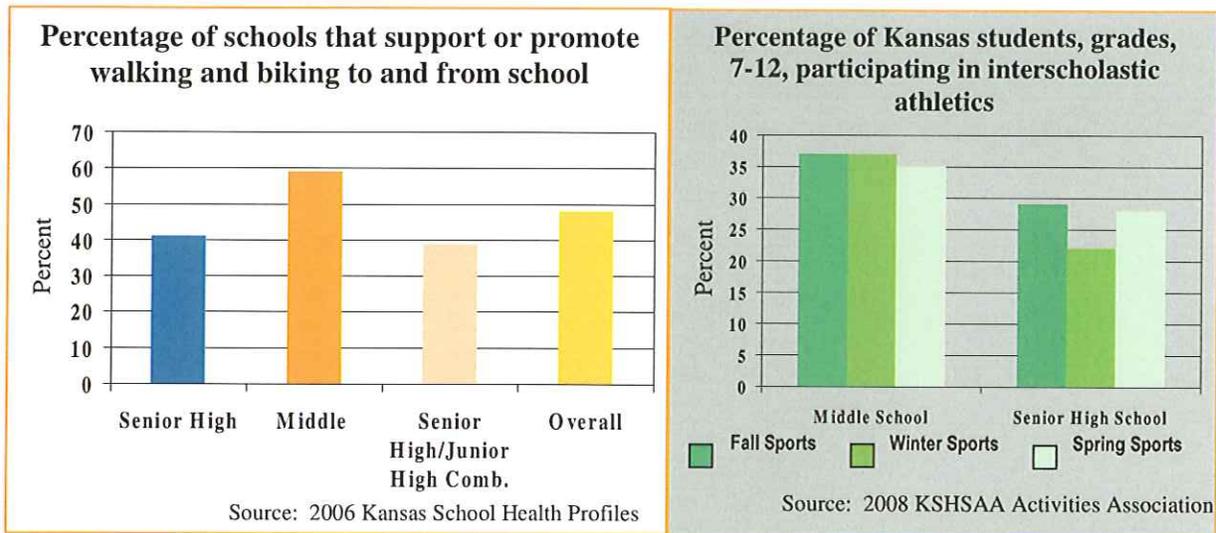
Kansas students in grades 7 and 8 come closest to meeting the Healthy People 2010 recommendation for adolescent physical activity. There are a number of possible reasons why a higher percentage of this age group tends to be more active. In Kansas, 7th grade marks the first year a student can participate in interscholastic athletics. According to data collected by KCSH, Kansas middle schools tend to offer more opportunities for their students to participate in intramural activities, physical activity clubs and programs that promote walking and biking to school. KCSH provides a framework for implementing similar programs and activities such as designating safe routes or preferred routes to school, and by providing onsite storage facilities for bicycles and helmets.

Percentage of Kansas middle, junior/senior highs and high schools that offer students opportunities to participate in intramural activities or physical activity clubs



Source: 2006 Kansas School Health Profiles

Due to limitations that exist in collecting routine and representative data at the elementary level, far less information is available to describe the elementary school environment. We do know that elementary schools operate in a more prescribed environment than middle schools and senior high schools. For example, almost all elementary students participate in physical education class and few elementary schools allow students access to vending machines. While these elements potentially lead to a healthier environment, there is still room for improvement in areas of nutrition curriculum development, increased exposure to nutrition and physical education, and height, weight and fitness indicator data collection.



Improving Students' Lifetime Health

The list of adverse health conditions that threaten Kansas children cannot be ignored. It's well documented that inactivity and poor nutritional choices contribute to obesity, diabetes, and other chronic conditions including cancer and cardiovascular disease.²⁰ Physical activity and dietary behavior patterns learned and established during childhood pay off by reducing the complications associated with these conditions. Limiting adverse health outcomes not only optimizes quality of life, but also contributes to reducing health care expenditures. Currently, Kansas spends \$12 billion on chronic disease in a single year.²¹ Obesity alone costs Kansans more than \$650 million per year on direct medical costs, of which \$143 million is paid by Medicaid.²²

"I think the greatest influence KCSH has had is the mindset that we, as a school district, can help our community members live healthier lives through instruction, support, example, resources, and just taking the lead in the journey towards healthy living."

Debbie Clawson, USD 247, Cherokee, KS

To address those contributing factors, schools, communities, and local and state governments must work together. Kansas has taken an important first step by adopting guidelines to encourage change in the school setting by advancing implementation of wellness policies. Evidence shows that school-based healthy eating and physical activity programs can be effective in preventing childhood obesity.²² Continued investment in Kansas Coordinated School Health, which provides an evidenced-based framework for action, assures that funds and technical assistance is available to school districts to facilitate progress toward achieving improved nutrition and increased physical activity goals. With adequate state commitment to implement the Coordinated School Health model, any school in Kansas can use the CSH framework as a tool to assist in accomplishing movement from "basic" to "exemplary" on the Wellness Guideline. With the infrastructure and support provided by the Kansas Coordinated School Health program, this is a reasonable and highly achievable goal.

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- ¹⁰ Kansas Statute 72-5128 *Food Service Program*, 2005.
- ¹¹ "KSDE's Model School Wellness Policy Guidelines" 2005.
- ¹² "Progress or Promises? What's Working For and Against Healthy Schools," Action for Healthy Kids, Fall 2008, pg 5. [From: <http://www.actionforhealthykids.org/newsroom.php>]
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**KANSAS HEALTH POLICY AUTHORITY
LEGISLATIVE COORDINATING COUNCIL STUDY #18
Kansas Health Transparency**

What is Health Transparency?

Health transparency is aimed at empowering individuals with greater access and ability to use information on cost and quality in order to make wise, informed decisions about the various health care services available. Consumers must have the information needed to answer questions such as: Which hospital has better outcomes from, performs the greatest number of, and has the lowest readmission rates following a specific surgery? How much is a specific surgery at one hospital, as compared with another? If one surgery or facility is more expensive than another, are the quality differences important and do they potentially offset the price variances? Additionally, what are the success rates of alternative surgeries/procedures? (US Chamber of Commerce). Such transparency will enable them to take more personal responsibility on how they spend their health care dollars. In addition to making more information available to consumers, increasing health transparency implicitly requires health literacy efforts to improve the ability of individuals to interpret, understand and apply health data to become better health care purchasers.

Kansas Health Online (KHO)

The Kansas health transparency initiative is a web portal called Kansas Health Online. It can be found at the URL www.kansashealthonline.com and provides consumer-focused information that:

- Promotes personal responsibility by promoting healthy lifestyles and preventive health interventions
- Promotes health literacy
- Offers a one-stop health resource for Kansans

KHO Website Content

- Diagnostic tools to help identify medical conditions and likely causes, starting with symptoms, e.g. WebMD Symptom Analyzer
- Disease management information, e.g. National Library of Medicine
- Medical dictionaries, glossaries and Frequently Asked Questions (FAQs)
- Links to local resources (Hospital, physician, and other health resource directory by specialty and zip code)
- Comparative metrics about:
 - Hospitals: JCAHO Core Measures – QualityCheck.org; CMS Hospital Quality Initiative (<http://www.hospitalcompare.hhs.gov>); AHRQ; NQF
 - Physicians: CMS Physician Quality Initiative
 - Insurers: HEDIS (incl. clinical and CAHPS surveys)
- Links to other nationally recognized websites: WebMD, Health.gov, ConsumerHealthRatings.com (Links to 300 organizations that rate hospitals/physicians/nursing homes/ home health agencies); CMS Website; Medicare.gov - Prescription Drug Plan Finder, etc.

- Modeled after other successful state websites, e.g. CHCF.org (California's Market and Policy Monitor for health transparency) ; FloridaCompareCare.gov
- Guidance from listening tours, Consumer Advisory Council for Kansas-specific consumer health issues

KHO - Progress in 2009

KansasHealthOnline.com, launched on January 15, 2008, by the KHPA in collaboration with the Kansas State Library and the Kansas University Dykes Medical Library, provides quality health information for consumers and empowers Kansans to make more informed decisions by providing information on health and health care in an easy to use and easy to understand format. Consumers are presented with tools, links, and information to compare hospitals, find doctors, compare health plans, analyze symptoms, get the latest information on medical conditions, make healthy lifestyle choices, and learn more about health policy.

Public libraries and the Internet are often the first place consumers turn for medical information. Research has indicated consumers who use the library as a health resource bring new information to their healthcare providers, make lifestyle changes, ask additional questions, and reduce their anxiety levels. In focus groups conducted by the Reference Point Foundation, consumers report that health information found through libraries is valuable and affects their health care decisions. In fact, 60 percent of the participants in the Reference Point Foundation project said that libraries were among their preferred sources of health information.

In addition to conducting workshops with librarians, Kansas Health Online conducted consumer focus groups across the state to learn about the health concerns and health information needs of Kansans (See Table 1).

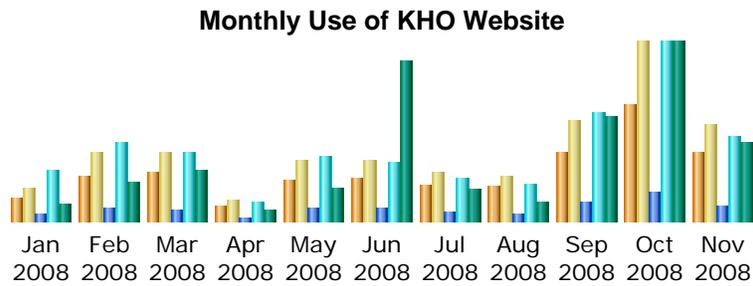
Table 1: Kansas Health Online Consumer Focus Group and Informational Workshop Schedule – 2008

Consumer Focus Groups				Workshops – Health Information using Kansas Health Online	
Coffeyville	7/16/2008	Dodge City	9/18/2008	Iola KHO Day	7/16/2008 10:00 AM
Pittsburg	7/16/2008	Manhattan	9/24/2008	Leavenworth KHO Day	8/18/2008 11:00 AM
Lawrence	8/18/2008	Belleville	9/24/2008	Norton KHO Day	9/17/2008 10:00 AM
Russell	9/16/2008	Council Grove	9/25/2008	Stockton KHO Day	9/17/2008 2:00 PM
Quinter	9/17/2008	Topeka	10/7/2008	Garden City KHO Day	9/18/2008 10:00 AM
Goodland	9/17/2008	Wichita	11/5/2008	Dodge City KHO Day	9/19/2008 1:00 PM
Ulysses	9/18/2008	Kansas City	TBA	<i>Manhattan KHO Day</i>	<i>9/24/2008 10:30 AM</i>
		Overland Park	TBA	Emporia KHO Day	9/25/2008 12:00 PM
				Wichita KHO Day	11/5/2008 12:00 AM
				Clearwater KHO Day	11/6/2008 12:00 AM

KHO - Tracking of Monthly Usage Statistics

Figure 1 shows the number of unique visitors, number of visits and other information about monthly use of the website.

Figure 1



Month	Unique visitors	Number of visits	Pages	Hits	Bandwidth
Jan 2008	385	554	3789	24770	10.58 KB
Feb 2008	743	1123	6320	38531	23.77 KB
Mar 2008	792	1148	5543	33236	30.28 KB
Apr 2008	242	335	1473	9405	6.08 KB
May 2008	689	1004	6498	31662	20.00 KB
Jun 2008	721	1002	6442	28722	96.34 KB
Jul 2008	578	810	3870	20361	18.12 KB
Aug 2008	560	741	3150	18141	10.76 KB
Sep 2008	1136	1651	9232	52409	63.09 KB
Oct 2008	1941	2961	13878	86741	107.20 KB
Nov 2008	1135	1588	7533	41437	47.01 KB

To gain an understanding of what specific topic areas are of interest to users of this website, the number of views for individual pages of the site was also tracked. Table 2 illustrates the cumulative views in decreasing order of frequency are as follows for the period 1/15/08 to 11/30/08:

Table 2

Section of the KHO Website	Number of views
Buying health care (Comparing hospitals, nursing homes, health plans, finding physicians)	3529
Learn about your medical condition	1660
Staying healthy (Prevention)	1565
Guide to Kansas Health Policy (Information to engage consumers more in the health policy process)	1365
Navigating the Health Care System	1350
Fun health websites for kids	1289
Health literacy (How information can work for you)	1028
Health Information on the Internet	522

Health Transparency Initiatives in Other States

The National Conference of State Legislatures compiled a comprehensive summary of health transparency in various states (*Report: State Legislation Relating to Transparency and Disclosure of Health and Hospital Charges*, December 2008). Excerpts from this summary are provided below as a comparison to the Kansas initiative:

- Cost information for Arizona hospitals and nursing home facilities can be found on the Department of Health Services, Division of Public Health Services web page.
- California currently posts hospital cost comparisons on its state government website and on the Office of Statewide Health Planning and Development Healthcare Quality and Analysis Division web page for prices of all services, goods and procedures for California hospitals.
- Florida has established a Web site that enables consumers to obtain data on hospitals' charges and readmission rates.
(<http://www.floridahealthfinder.gov/CompareCare/SelectChoice.aspx>).
- The Iowa Hospital Association has a Web site that provides information on every charge for any type of inpatient procedure in all Iowa hospitals. Iowa Hospital PricePoint is also the access point for aggregate discount information for private insurance, Medicare, and Medicaid, allowing users to compare charges to revenue for hospital services.
- Louisiana has a voluntary reporting program called, "Louisiana Hospital Inform" that is maintained by the Louisiana Hospital Association. The website provides pricing data on the most common Medicare inpatient and outpatient services, as well as quality data, demographic information and services offered at Louisiana hospitals.
- The Maryland Health Care Commission provides consumers with an online hospital pricing guide that lists, for each acute care hospital in Maryland, the number of cases, the average charge per case, and the average charge per day for the 15 most common diagnoses.
- Massachusetts, as part of its new health care reform law, will establish a website that allows consumers to compare the quality of hospitals and clinics, as well as the average payment each charges for a range of services. Massachusetts already has a website, but the new site will have much more information, including prices for hospitals and for the cost of prescriptions at individual pharmacies.
- New Hampshire recently unveiled a hospital price website called "New Hampshire PricePoint," which is sponsored and maintained by the New Hampshire Hospital Association. There is also a voluntary effort in Oregon called "Oregon Pricepoint," which is sponsored and maintained by the Oregon Association of Hospitals and Health Systems. These sites allow health care consumers to receive basic, facility-specific information about services and charges.
- New Jersey -Two recent Web sites have been launched recently to help consumers make informed choices regarding price and quality of hospital services in New Jersey. The site www.njhospitalpricecompare.com includes a Top 25 DRG Search; a separate site, www.njhospitalcarecompare.com covers quality of care.
- The Utah Public Employee Health Plans (PEHP) has published an online Treatment Cost Estimator Home and a separate PEHP Average Costs list for infant deliveries, effective 2008.
- In Wisconsin, information on hospital charges for common procedures is available online; basic price information is available on a web site run by the Wisconsin Hospital Association that draws on data collected by the state. Price Point, displays typical charges and lengths of stay for individual hospitals, alongside state and county averages.

Conclusion

The Kansas Health Online is a first step towards health transparency in Kansas comparable to ongoing efforts in other states. The predominantly “portal approach” (compilation of authoritative information already available in a centralized, easy-to-use manner) has already

shown promise as shown by the increasing usage rates in the first year after its launch. However, further work is needed in leveraging the various data sources maintained by key health agencies and organizations in the State to generating cost and quality information. The work of the Data Consortium, a multi-stakeholder, advisory committee to the Kansas Health Policy Authority Board comprising over 22 key health organizations is anticipated to help in augmenting the KHO web-site through the reporting of some health indicators in the areas of access to care, affordability and sustainability, quality and efficiency, and health and wellness that are of interest to consumers in 2009 and beyond.

Public reporting and dissemination of price and quality data is just the first step in health transparency. Incentives must also be aligned to reward quality and a culture of outcomes-focused behavior needs to be created amongst all the key players in the health care field. As summarized by the US Chamber of Commerce, coordination among the concepts of quality improvement and reporting, the establishment and dissemination of evidence based medicine protocols, widespread adoption and use of health information technology, and pay for performance are all key ingredients to creating and promoting transparency.

APPENDIX: LIST OF OTHER TRANSPARENCY WEBSITES

The Oklahoma Hospital Association has created the site, <http://www.okhospitalpricing.org/> , a one-stop shopping place for pricing of procedures. Patients who are faced with inpatient surgeries can shop around for various prices that are charged by hospitals and get a better idea of what to expect.

<http://www.floridahealthfinder.gov/> (Both quality and pricing info -- targeted at two audiences: consumers and professionals/researchers)

<http://www.calhospitalfinance.net/> (Financial ratios and market indicators such as profitability, revenues, operating margins incl. DSH, etc. for hospitals -- aimed at a more business-savvy audience such as policy-makers/market regulators)

JCAHO Core Measures – www.QualityCheck.org

Hospital Quality Initiative – www.hospitalcompare.hhs.gov

Information on transparency for the Office of the President
<http://www.whitehouse.gov/news/releases/2006/08/20060822.html>

HHS website on value driven purchasing <http://www.hhs.gov/valuedriven/>

About Health Transparency
<http://www.abouthealthtransparency.org/>

**KANSAS HEALTH POLICY AUTHORITY
LEGISLATIVE COORDINATING COUNCIL STUDY #19
Need for a Statutory Legislative Committee on Health Futures**

Introduction

The 2008 edition of the Kansas Legislative Handbook says this about legislative standing committees: “Most standing committees are created to evaluate and report on bills assigned to them...Not all committees are of equal importance. Both the quality and quantity of bills assigned varies from committee to committee and from year to year.¹” During the 2008 legislative session, there were three standing committees which discussed health-related legislation—the Senate Public Health and Welfare Committee and Health Care Strategies Committee and the House Health and Human Services Committee. This study will analyze the work of these committees in recent years, as well as the interim Joint Committee on Health Policy Oversight, in order to determine whether or not an additional Health Futures Committee is necessary.

Methods

In the Kansas Legislature, there is no formal record of the jurisdiction or charges of standing committees. Therefore, in order to analyze the activities and subject matter heard by each of the health committees we used a historical approach. This study examines the bills heard in each of these committees during the 2005-2008 legislative sessions and the work of the Joint Committee on Health Policy Oversight since its creation in 2005. Additionally, where available, we provide information on the charter and charge of each of the health committees and a summary of the topics covered.

Results

The Senate Health Care Strategies Committee

The Senate Health Care Strategies Committee was created and held its first meetings during the 2005 legislative session. According to the minutes of the committee’s first meeting on January 20, 2005, the committee was charged by the Senate President to “analyze health care costs, address concerns about the Medicaid system, look at long term strategies for addressing health care costs, and see what the Committee can do to make sure affordable health care is available to all Kansans.²”

The committee has been chaired by Senator Susan Wagle since its inception. Committee membership in the 2008 session included: Vice Chairperson Senator Pete Brungardt, Ranking Minority Member Senator Mark Gilstrap, Senator Nick Jordan, Senator Phil Journey, Senator Peggy Palmer, and Senator Vicki Schmidt. The committee was scheduled to meet two times per week on Mondays and Tuesdays at 1:30 p.m.

The workload of the Health Care Strategies Committee has varied from year to year. The following is a summary of the committee’s action from 2005 to 2008, compiled from the Committee Action Index for each year.

¹ 2008 Kansas Legislative Handbook. Page 5

² <http://www.kslegislature.org/committeeminutes/0506/senate/shealthstragtegies/shealthstrategies01202005.pdf>

- During the 2005 session, a total of five bills were introduced in the committee, but only two bills received hearings. Senate Bill 235, an act concerning hospitals, and instituting a moratorium on the establishment of certain hospitals prior to July 1, 2006 was heard on March 2 and 3, but later died in committee. Senate Bill 306, an act which established the Kansas Health Policy Authority and its powers, duties and functions, was heard on March 29, and the bill passed out of committee favorably on March 30.
- In 2006, four bills were introduced, but only HB 2608 was heard. The bill dealt with the Kansas Health Policy Authority and related to administrative hearings. A hearing was held on February 7, and HB 2608 passed out of the committee favorably the same day with the recommendation that it be placed on the Consent Calendar.
- The 2007 session saw only two bills, Senate Bill 309, concerning the Kansas Health Care Connector Act and Senate Bill 323, concerning the Kansas Health Policy Authority. Hearings were held on both bills. SB 309 was heard on February 20, March 13, and March 19. Final action was taken on the bill March 19, when substitute language for the bill passed out of committee favorably. Senate Bill 323 was heard on February 19, with continued discussion and final action on February 21. Substitute for Senate Bill 323 passed out of committee favorably on February 19.
- In 2008 the committee heard four bills. The Medical Marijuana Defense Act, Senate Bill 556, was heard on February 11 but never made it out of committee. Hearings were held for Senate Bill 541 on February 18 and 19, which dealt with the Kansas Health Policy Authority. On March 10 the bill passed out of committee with favorable status. Senate Concurrent Resolution 1608, a concurrent resolution memorializing Congress to allow states greater flexibility in the use of federal health care funding, was heard March 17 and passed out of committee on March 24 (QUESTION ON THE STATUS). An important bill to come out of committee in 2008 was House Bill 2620, a bill concerning the Kansas Board of Healing Arts. Hearings were held on March 18 and 24. The committee amended the bill and it passed out of committee favorably on March 25.

It was recently announced that the Senate Health Care Strategies Committee will not exist during the 2009 legislative session.

The Senate Public Health and Welfare Committee

The Senate Public Health and Welfare Committee existed prior to the creation of the Health Care Strategies committee. Public Health and Welfare has traditionally heard most of the legislation in the Senate dealing with health-related matters. The following tables list the legislation considered by the Committee during each legislative session from 2005 to 2008.

Committee Action Index 2005

BILL NUMBER	SUBJECT	DATE OF HEARING/ DISCUSSION	DATE OF FINAL ACTION BY FULL COMMITTEE
SB 10	Schools; self-administration of medication	1/24/05	1/31/05 Passed as amended
SB 86	Cancer registry, follow-up projects on cancer cases for public health purposes.	1/31/05	No Action
SB 91	Dental board fees.	2/1/05	2/14/05 Passed favorably as amended
SB 92	Abuse of persons in adult care homes, duties of department on aging.	1/31/05	1/31/05 Passed and placed on Consent Calendar
SB 115	Investigation period involving reports of abuse, neglect or exploitation of certain persons.	2/8/05	2/8/05 Passed favorably
SB 116	Injunctive authority to cease operations of unlicensed psychiatric hospitals, community mental health centers and facilities for the mentally ill, mentally retarded or other handicapped persons.	2/8/05	2/15/05 Passed favorably as amended
SB 154	Food service standards for public schools.	2/ 15/05	2/17/05 Passed favorably as amended
SB 155	Abortions may be performed only by physicians, and on fetuses aged 16 weeks or more only at ambulatory surgical centers or hospitals.	No Action	No Action
SB 183	Scope of practice of federally active licensees under the healing arts act.	2/14/05	2/17/05 Passed favorably as amended
SB 208	Concerning child care facilities and family day care homes; denial or revocation of license.	2/14/05	No Action
SB 216	Infectious or contagious diseases, quarantine and isolation of individuals.	2/17/05	2/17/05 Passed favorably
SB 217	Tuberculosis evaluations for faculty, staff and students who enter high school, college or university classrooms.	2/15/05	3/8/05 Passed favorably as amended
SB 222	Professional counseling license, qualifications, graduates of programs requiring less than 12 on-campus credit hours.	No Action	No Action
SB 254	Persons not engaged in practice of healing arts.	2/22/05	2/22/05 Passed favorably as amended
SCR 1604	School food programs.	2/7/05	2/7/05 Passed favorably
HB 2077	Establishing a cancer drug repository program.	3/7/05	3/14/05 Passed favorably as amended
HB 2086	Home health agencies surveys.	3/8/05	3/8/05 Passed favorably as amended
Sub HB 2088	Uniform vital statistics.	3/10/05	No Action
HB 2153	Secretary of aging, state long-term care ombudsman.	3/9/05	3/9/05 Passed favorably as amended
HB 2154	Repeal of K.S.A. 65-1627d, 65-1627e and 65-1627g.	3/9/05	3/9/05 Passed favorably and placed on consent calendar
HB 2155	Prescription refills.	3/10/05	3/16/05 Passed favorably as amended

Committee Action Index 2006

BILL NUMBER	SUBJECT	DATE OF HEARING/ DISCUSSION	DATE OF FINAL ACTION BY FULL COMMITTEE
SB 86	The cancer registry; follow-up projects on cancer cases	No Action	No Action
SB 92	Abuse, neglect or exploitation of persons relating to the department of aging; concerning duties thereof; concerning withholding or withdrawal of life-saving or life-sustaining care of certain persons	No Action	No Action
SB 155	Abortion	No Action	No Action
SB 208	Children and minors; relating to licensure of a child care facility or family day care home	No Action	No Action
SB 222	An act concerning professional counselors; relating to licensure by the behavioral sciences regulatory board	No Action	No Action
SB 290	Concerning promulgation of rules and regulations by the secretary of social and rehabilitation services; relating to the prior authorization program	No Action	No Action
SB 314	Office based surgeries; providing for regulation of physicians who perform office-based surgeries and special procedures	No Action	No Action
SB425	Hospitals and ambulatory surgical centers; relating to disclosure of prices	No Action	No Action
SB 426	Relating to minors; concerning the donation of blood	2/1/06	2/8/06
SB 469	The behavioral sciences regulatory board; relating to impaired licensees	2/9/06	2/22/06
SB 470	The behavioral sciences; relating to temporary licenses	2/9/06	2/9/06
SB 511	Health clubs; requiring the availability of an automated external defibrillator and the availability during business hours of a qualified person to operate such defibrillator	2/22/06	No Action
SB 528	Public health; relating to the reporting of statistical data regarding termination of pregnancies	2/15/06	2/22/06
SB 529	Abortion	2/15/06	2/22/06
SB 530	Death certificates	No Action	No Action
SB 537	Public health; relating to vaccinations	3/1/06	No Action
SB546	The board of emergency medical services; establishing a statewide data collection system	3/2/06	3/16/06
SB581	Office based surgeries; providing for inspection of offices at which office-based surgeries and special procedures are performed	No Action	No Action
HB2088	The uniform vital statistics act	No Action	No Action
Sub HB 2088	Abandonment of certain infants; making certain conduct unlawful, providing penalties	4/28/06	4/28/06
HB 2225	Pharmacists; relating to renal dialysis facility pharmacist consultants	No Action	No Action
HB 2284	Right to breastfeed; jury duty exception	2/2/06	2/8/06
HB 2285	Health care; relating to the board of examiners for hearing instruments, membership, powers and duties, relating to licensure, disciplinary actions; fees and penalties	3/15/06	3/15/06
HB 2342	Nurses and physician assistants; relating to the pronouncement of death	3/15/06	No Action
HB 2396	Colleges and universities; relating to students residing in student housing; requiring policies	No Action	No Action

	regarding vaccination for meningitis		
HB 2496	Licensure and licenses; relating to the occupational therapy practice act; continuing education requirements	No Action	No Action
HB 2497	Restrictions on persons maintaining or residing, working or volunteering at child care facilities or family day care homes	No Action	No Action
HB 2649	Health care; relating to a pain patient's bill of rights	3/16/06	3/22/06
HB2678	Renal dialysis facility pharmacies	3/8/06	3/8/06
HB2752	Health care; relating to trauma facilities	3/15/06	3/16/06
HB 2792	Abortions; concerning minors	No Action	No Action
HB2813	Concerning the practice of nursing	No Action	No Action
HB2825	The establishment of a voluntary data bank of available interpreters for certain purposes and development of qualifications for interpreters	3/16/06	3/22/06
HB2829	The secretary of health and environment; providing for regulation of clinics and facilities where office-based surgeries and special procedures are performed	No Action	No Action
HB2830	Concerning pharmacists and pharmacy; relating to registration of pharmacy technicians	3/9/06	3/9/06
HB2831	Concerning pharmacists and pharmacy; relating to the accreditation council for pharmacy	3/9/06	3/9/06
HCR5011	A concurrent resolution expressing the Legislature's recognition and appreciation for family caregivers throughout the state	3/16/06	3/16/06

Committee Action Index 2007

BILL NUMBER	SUBJECT	DATE OF HEARING/ DISCUSSION	DATE OF FINAL ACTION BY FULL COMMITTEE
SB 1	Public health, relating to vaccinations	3/22/07	No Action
SB 62	Restricting the prescribing, ordering, dispensing, administering, selling, supplying or giving certain amphetamine or sympathomimeticamine controlled substances	1/16/07	1/16/07
SB 63	Concerning filling prescriptions	1/16/07	1/16/07
SB 72	Mortuary arts; relating to funeral directors and licenses	1/16/07	1/16/07
SB 82	The healing arts act	1/25/07	1/25/07
SB 104	Concerning the board of nursing; membership thereon	1/31/07	2/1/07
SB 105	Concerning the board of nursing	1/31/07	2/1/07
SB 106	Concerning the practice of nursing	2/8/07	2/8/07
SB 107	The board of nursing; concerning fingerprinting and criminal history records checks; creating the criminal background and fingerprinting fund	1/23/07 2/13/07	2/13/07
SB 116	Schools; health programs	1/23/07	No Action
SB 117	Health insurance; relating to dependent coverage	No Action	No Action
SB 176	Dental hygienists; relating issuance of permits, authorized practice	2/7/07	2/7/07
SB 177	The department of health and environment; relating to education and screening for congenital hypothyroidism	No Action	No Action
SB 178	Cancer registry to confidential data	2/8/07, 2/13/07	2/13/07
SB 179	An act concerning mortuary arts; assistant funeral director's license	2/13/07	2/13/07
SB 181	An act concerning hospitals and ambulatory	No Action	No Action

	surgical centers; relating to disclosure of prices		
SB 201	Restrictions on persons maintaining or residing, working or volunteering at child care facilities or family day care homes	2/14/07	2/15/07
SB 202	Child care facilities; relating to definitions	2/14/07	2/15/07
SB 229	Prescription drugs; creating the prescription confidentiality act	2/15/07	No Action
SB 230	Alcohol or substance abuse; relating to the care and treatment act	No Action	No Action
SB 243	An act concerning health insurance; relating to dependent coverage	No Action	No Action
SB 250	Motor vehicles; prohibiting smoking when certain children are in motor vehicle	2/7/07	No Action
SB 284	An act concerning the radiologists practice act	2/14/07	2/15/07
SB 285	Concerning the healing arts act; prohibiting billing for anatomic pathology services in certain circumstances	2/15/07	2/15/07
SB 300	Department of corrections; providing for a mandatory HIV education program	No Action	No Action
SB 302	Creating a controlled substances monitoring task force; prescribing the duties thereof	2/21/07	2/21/07
SB 354	The department of social and rehabilitation services; relating to alcohol and drug addiction treatment	2/28/07	3/1/07
HB 2096	The state board of pharmacy; relating to meetings	3/1/07	3/1/07
HB 2097	Pharmacists; relating to the giving of vaccinations	No Action	No Action
HB 2133	Fire inspections; establishing a two-tier informal dispute resolution procedure for medical care facilities, adult care homes, assisted living facilities or special hospitals	No Action	No Action
HB 2181	Social workers; relating to hours of continuing education needed for license reinstatement	3/1/07	3/1/07
HB 2182	The behavioral sciences regulatory board; relating to temporary permits to practice for out-of-state licenses	3/1/07	3/1/07
HB 2214	The Kansas dental board; relating to sedation permits	3/7/07	3/14/07
HB 2216	Dentists and dental hygienists; relating to licensure	3/7/07	3/7/07
HB 2341	Enacting the disposition of fetal remains act	No Action	No Action
HB 2418	The definition of general hospital	3/15/07	No Action
HB 2483	Physical therapy	3/14/07	3/21/07

Committee Action Index 2008

BILL NUMBER	SUBJECT	DATE OF HEARING/ DISCUSSION	DATE OF FINAL ACTION BY FULL COMMITTEE
SB 1	Public health, relating to vaccinations.	No Action	No Action
SB 116	Schools; health programs, amending KSA 72-5214 and repealing the existing section.	No Action	No Action
SB 117	Health insurance relating to dependent coverage; amending KSA 40-2209d and 40-2218 and KSA 2006 Supp. 40-2118 and repealing the existing sections	No Action	No Action
SB 177	Department of health and environment; relating to education and screening for congenital hypothyroidism, galatosemia, phenylketonuria and other genetic diseases and disorders; assistance	No Action	No Action

	for certain expenses; amending KSA 2006 Supp. 65-180 and repealing existing sections.		
SB 181	Hospitals and ambulatory surgical centers; relating to disclosure of prices.	No Action	No Action
SB 229	Prescription drugs; creating the prescription confidentiality act.	No Action	No Action
SB 230	Alcohol or substance abuse; relating to the care and treatment act; definitions; amending KSA 59-29b46 and repealing the existing section.	No Action	No Action
SB 250	Motor vehicles; prohibiting smoking when certain children are in motor vehicle; amending KSA 8-2106 and repealing the existing section.	No Action	No Action
SB 300	Department of corrections; providing for a mandatory HIV education program; amending KSA 3006 Supp. 75-5210 and repealing the existing section.	No Action	No Action
SB 396	Nurse licensure compact; directing the governor to enter into a compact; approving and specifying terms of the compact; amending KSA 651114 and 651120 and KSA2007	No Action	No Action
SB 490	Food, drug and cosmetic act; concerning prohibited procedure of administering phosphatidylcholine and sodium deoxycholate by injection; amending KSA 65-656 and 65-657 and repealing the existing sections.	No Action	No Action
SB 491	Controlled substances; enacting the prescription monitoring program act; creating the prescription monitoring program advisory committee. (Substitute SB 491)	2/04/08, 2/07/08	Be Passed As Amended 02/13/08
SB 503	Controlled substances; enacting the methamphetamine precursor recording act.	No Action	No Action
SB 529	Educational awareness regarding meningococcal meningitis vaccine. (Be passed as amended on 2/13/08. Substitute HB 2097 amended to include SB 529 and SB 548 on 3/26/08)	2/13/08	Substitute HB 2097 amended to include SB 529 and SB 548 Be Passed 03/26/08
SB 548	School-based influenza vaccination pilot program. (Be passed as amended on 2/13/08. Substitute HB 2097 amended to include SB 529 and SB 548 on 3/26/08)	2/13/08	Substitute HB 2097 amended to include SB 529 and SB 548 Be Passed 03/26/08
SB 549	Board of pharmacy; nonresident pharmacy regulations and continuous quality improvement programs. (Substitute SB 549)	2/20/08, 2/21/08	Be Passed As Amended 02/21/08
SB 566	Attendant care workers act; study of wages and benefits for attendant care workers who provide services for individuals in need of long-term in home and community settings. (Substitute SB 566)	3/12/08	Be Passed As Amended 03/19/08
SB 568	Optometrist's and Kansas nonprofit low vision rehabilitation centers.	3/11/08	No Action
SB 572	The massage therapy practice act; establishing the board for licensure and regulation of the massage therapists.	No Action	No Action
SB 596	State board of healing arts; cosmetic or aesthetic purpose included in the practice. (Substitute SB 596)	2/20/08, 2/21/08	Be Passed As Amended 02/21/08
SB 643	Licensing requirements for food service establishments	3/06/05	No Action

SB 694	Internet pharmacies; registration of; board of pharmacy	No Action	No Action
SB 697	Funding recommended for primary care safety net clinics; appropriation recommended to KDHE and KHPA.	4/03/08	Be Passed As Amended 04/03/08
HB 2097	An act concerning pharmacists; relating to the giving of vaccinations; amending KSA 3006 Supp. 65-1635a and repealing the existing section.		Be Passed As Amended 03/26/08
HB 2207	Relating to the Kansas board of pharmacy, authorizing emergency proceedings under subsections (d), (e) and(f)ofK.S.A.65-1627.	3/06/08	Be passed As Amended 03/26/08
HB 2341	An act enacting the disposition of fetal remains act. (Senate Substitute HB 2341)	1/16/08, 1/30/08	Be Passed As Amended 01/30/08
HB2418	An act concerning the definition of general hospital; amending KSA 65-425 and repealing the existing section.	No Action	No Action
HB 2570	Persons authorized to make adoption assessments	3/12/08, 3/19/08	Be Passed 03/19/08
HB 2695	Athletic trainer licensure	03/13/08	Be Passed 03/13/08
HB 2672	An act concerning the Kansas health policy authority; amending KSA 38-2006, 39-968, and 65-435a and repealing the existing sections; also repealing KSA 46-2507	03/26/08	Be Passed As Amended 03/26/08
HB 2702	Excepted acts and reciprocity concerning the practice of dentistry	03/13/08	Be Passed 03/13/08
HB 2721	Board of cosmetology; licensing requirements	03/19/08 03/26/08	Be Passed As Amended 03/26/08
HB 2781	Dental offices; permitting an additional office in counties with low population densities	03/13/08	Be Passed 03/13/08

The House Health and Human Services Committee

The House Health and Human Services Committee is currently the only standing health committee in the Kansas House of Representatives. Health and Human Services hears nearly all of the legislation in the House dealing with health-related matters. The following tables list the legislation considered by the Committee during each legislative session from 2005 to 2008.

Committee Action Index 2005

BILL NUMBER	SUBJECT	DATE OF HEARING/ DISCUSSION	DATE OF FINAL ACTION BY FULL COMMITTEE
Sub for HB 2088	Giving birth without medical assistance	2/1/05	2/16/05, Passed favorably
HB 2086	Extending the time between surveys for home-health agencies	2/1/05	2/1/05, Passed favorably, placed on Consent Calendar
HB 2137	Health food choices in school vending machines	2/2/05 2/3/05	No Action
HB 2077	Establishing a cancer drug repository program by the State Board of Pharmacy	2/3/05	2/22/05, Passed favorably
HB 2204	Sales tax exemption for health and fitness organizations	2/7/05	2/14/05, Passed favorably
HB 2153	Long-term care ombudsman moved from KDHE to Department of Aging	2/8/05	2/8/05, Passed favorably as amended
HB 2154	Repealing certain statutes regarding pharmacy hearings	2/8/05	2/8/05, Passed favorably, placed on Consent Calendar
HB 2225	Concerning the Board of Pharmacy regarding renal dialysis	2/8/05	2/8/05, Passed favorably, placed on Consent Calendar
HB 2155	Pharmacy refills on an emergency basis	2/8/05	2/8/05, Passed favorably as

			amended
HB 2256	Relating to advanced registered nurse practitioners	2/9/05 2/10/05	No Action
HB 2156	Registration of pharmacy technicians under the Board of Pharmacy	2/14/05	2/14/05, Passed favorably, placed on Consent Calendar
HB 2336	Amending the regulation of optometrists	2/14/05	2/14/05, Passed favorably as amended
HB 2178	Amending the Senior Care Act to allow preventive health services	2/15/05	2/16/05, Passed favorably, placed on Consent Calendar
HB 2208	Establishing a task force on the prevention and treatment of obesity	2/15/05	No Action
HB 2330	Amending the radiologic technologists practices act	2/15/05	2/15/05, Passed favorably as amended
HB 2211	Ambulances carrying an explanation of legal documents	2/16/05	2/22/05, Tabled
HB 2158	Attendants' certificates for Emergency Medical Services	2/16/05	2/22/05, Passed favorably
HB 2284	Concerning children related to breastfeeding	2/17/05	2/17/05, Passed favorably
HB 2285	Relating to the Board of Examiners for Hearing Instruments	2/17/05	2/17/05, Passed favorably
HB 2417	Creating the council on obesity prevention and management	2/21/05	2/22/05, Passed favorably as amended
HB 2337	Creating the crime of illegal importation of prescription drugs	2/21/05	2/22/05, Passed favorably
HCR 5011	Joint Memorial recognizing family care-givers	3/14/05	3/14/05, Passed favorably
SB 115	Investigation period involving reports of abuse, neglect or exploitation of certain persons	3/8/05	3/8/05, Passed favorably, Consent Calendar
SB 116	An act concerning SRS, providing injunctive authority against unlicensed facilities	3/8/05	3/14/05, Passed favorably as amended
SCR 1604	Concerning healthy eating and physical activity in public elementary and secondary schools	3/9/05	3/14/05, Passed favorably
SB 183	Scope of practice of federally active licensees under the healing arts act	3/9/05	3/10/05, Passed favorably
SB 91	Regarding the Kansas Dental Board concerning fees and regulation of mobile dental clinics	3/10/05	3/10/05, Passed favorably as amended
HB 2496	Occupational therapy practice act definitions	3/14/05	3/14/05, Passed favorably
HB 2503	Regulation, licensing and standards for operation of abortion clinics	3/15/05	3/16/05, Passed favorably
SB 216	Infectious diseases, quarantine and isolation of individuals	3/16/05	3/16/05, Passed favorably
HB 2396	Public post-secondary education institutions, on-campus housing, meningococcal disease vaccinations, affidavit procedure	3/16/05	No Action
SB 10	Schools, self-administration of medication	3/21/05	3/22/05, Passed favorably as amended
SB 254	Persons not engaged in practice of healing arts	3/21/05	3/22/05, Passed favorably
SB 92	Abuse of persons in adult care homes, duties of Department on Aging	3/22/05	3/22/05, Passed favorably
HCR 6021	Cervical cancer screening	3/16/05	3/16/05, Passed favorably
HCR 5013	Taiwan as observer for World Health Organization	3/21/05	3/21/05, Passed favorably as amended

Committee Bill Index 2006

BILL NUMBER	SUBJECT	DATE OF HEARING/ DISCUSSION	DATE OF FINAL ACTION BY FULL COMMITTEE
HB 2256	Health care; advanced registered nurse practitioners	No Action	No Action
HB 2342	Determination and pronouncement of death by	2/9/06	2/13/06, Passed favorably as

	advanced registered nurse practitioners and registered professional nurses in adult care homes and licensed hospices		amended
HB 2396	All colleges and universities; requiring policies regarding vaccination for meningitis	3/6/06	3/9/06, Substitute bill passed favorably
HB 2397	Distribution of certain prescription drugs; enacting the wholesale licensure and prescription medication integrity act	2/7/06	3/21/06, Amended into SB 217, passed favorably as amended
HB 2452	Board of nursing; relating to a central registry of information concerning licensees	2/8/06	No Action
HB 2458	Department of Health and Environment; regulation of clinics and facilities where office-based surgeries and special procedures are performed	No Action	No Action
HB 2497	Restrictions on persons maintaining or residing, working or volunteering at child care facilities or family day care homes	2/8/06	2/14/06, Passed favorably as amended
HB 2649	Pain patient's bill of rights	2/1/06	2/20/06, Passed favorably as amended
HB 2650	Children in need of care; foster parents as interested parties; custody awarded to the Secretary; false reporting of abuse; temporary custody; immediate physical danger	No Action	No Action
HB 2660	The behavioral sciences regulatory board; relating to membership	1/31/06	No Action
HB 2678	Renal dialysis facility pharmacies	2/2/06	2/9/06, Passed favorably, placed on Consent Calendar
HB 2713	Practice of physical therapy	No Action	No Action
HB 2715	State radiation control, fees	2/13/06	No Action
HB 2734	State boards, commissions and authorities; online education and licensure	2/20/06	No Action
HB 2737	Creating the Board of Health Professions and its members, powers and duties	No Action	No Action
HB 2738	Schools; healthy food choices in vending machines	No Action	No Action
HB 2739	Crimes and punishments for tobacco use in medical care facility buildings and property	2/20/06	2/21/06, Passed favorably
HB 2752	Trauma facilities and policies regarding vaccination for meningitis	2/15/06	2/20/06, Passed favorably
HB 2785	Certain child care facilities; day care facilities	No Action	No Action
HB 2800	Abortion clinics; providing for regulation, licensing and standards for the operation thereof; providing penalties for violations and authorizing injunctive actions	No Action	No Action
HB 2803	Public health; emergency contraception; providing for education	No Action	No Action
HB 2813	Practice of nursing, licensure requirements	3/2/06	3/9/06, Passed favorably
HB 2820	Distribution of certain prescription drugs; enacting the wholesale licensure and prescription medication integrity act	3/1/06, 3/15/06	3/21/06, Amended into SB 217, passed favorably as amended
HB 2825	Data bank interpreters	2/21/06	2/21/06, Substitute bill passed favorably as amended
HB 2827	Pharmacists and pharmacy; home health agencies maintaining an emergency medication kit	No Action	No Action
HB 2829	Secretary of health and environment; regulation of clinics and facilities where office-based surgeries and special procedures are performed	2/14/06	2/15/06, Passed favorably
HB 2830	Registration of pharmacy technicians	2/21/06	2/21/06, Passed favorably
HB 2831	Pharmacists and pharmacy; the accreditation council for pharmacy	2/21/06	2/21/06, Passed favorably
HB 2852	Board of Nursing; licensure of mental health technicians concerning fingerprinting and criminal history records checks	3/2/06	No Action

HB 2853	Board of Nursing; licensure of mental health technicians concerning fingerprinting and criminal history records checks	3/2/06	No Action
HB 2855	Health care directives registry administered by the Secretary of Health and Environment	No Action	No Action
HB 2870	Nutritional food in schools	No Action	No Action
HB 2871	Board of Nursing; relating to a central registry of information concerning nurses	No Action	No Action
HB 2876	Public health; reporting of statistical data regarding termination of pregnancies	No Action	No Action
HB 2877	Abortion; written report thereon	No Action	No Action
HB 2920	The umbilical cord donation information act	No Action	No Action
HB 2933	Qualifications for the Director of the Division of Health	No Action	No Action
HB 2941	The Prescription Privacy Act	No Action	No Action
HB 2971	Department of Health and Environment; education and screening for certain genetic diseases and disorders; assistance for certain expenses	No Action	No Action
HB 2977	The state fire marshal; fire prevention and education opportunities for certain persons	3/13/06	3/15/06, Passed favorably
HB 3011	Health and health care; prescribing disclosure and availability of prices charged by certain health care providers for health or medical care services	3/21/06	No Action
HCR 5011	The Legislature's recognition and appreciation for family caregivers throughout the state.	2/16/06	2/16/06, Passed favorably as amended
HCR 5031	Urging providers of health insurance to encourage certain insured individuals to have an up-to-date living will and advance directives	2/16/06	No Action
SB 217	Tuberculosis evaluations for certain faculty, staff and students who enter high school, college or university classrooms	3/21/06	3/21/06, Passed favorably as amended
SB 263	Membership of the emergency medical services board	2/2/06	No Action
SB 469	The behavioral sciences regulatory board; impaired licensees	3/14/06	No Action
SB 470	The behavioral sciences regulatory board; temporary licenses	3/15/06	3/15/06, Passed favorably
SB 528	Public health; reporting of statistical data regarding termination of pregnancies	3/20/06	3/21/06, Passed favorably as amended

Committee Action Index 2007

BILL NUMBER	SUBJECT	DATE OF HEARING/ DISCUSSION	DATE OF FINAL ACTION BY FULL COMMITTEE
HB 2009	Vaccinations by pharmacists to persons of any age.	1/31/07	No Action
HB 2030	Practice privileges for institutional licensees under the Kansas healing arts act.	No Action	No Action
HB 2096	Board of pharmacy, concerning meetings.	2/15	2/15, Passed Favorably
HB 2097	Administering of vaccines by pharmacists, pharmacy students and interns to persons age five and older.	1/31/07	2/13, Passed Favorably as Amended
HB 2098	Defining certain terms relating to human cloning.	2/5/07	2/13, Passed Favorably
HB 2162	Use of cigarettes and tobacco products prohibited on school property, fine of \$25 to \$100.	No Action	No Action
HB 2174	Board of cosmetology; standards of practice.	2/12/07	No Action
HB 2180	Behavioral sciences regulatory board's rules and regulations authority concerning impaired licensees.	2/1/07	No Action

HB 2181	Hours of continuing education required for reinstatement of social work license.	2/1/07	2/1/07, Passed Favorably
HB 2182	Temporary permits to practice from the behavioral sciences regulatory board for out-of-state licensees.	2/1/07	2/1/07, Passed Favorably
HB 2205	Prostitution; severity level 10, person felony if offender knows he/she has an infectious disease.	No Action	No Action
HB 2213	Child care facilities regulation.	No Action	No Action
HB 2214	Regulation of sedation permits by Kansas dental board.	2/19/07	2/20/07, Passed Favorably as Amended
HB 2215	Kansas dental board, fee for permits.	No Action	No Action
HB 2216	License renewal of dentists and dental hygienists.	2/19/07	2/19/07, Passed Favorably as Amended
HB 2227	Requiring female students enrolling in grade six to be inoculated against the human papilloma virus.	2/7/07	No Action
HB 2235	Board of nursing fees.	No Action	No Action
HB 2239	Health care providers, risk management, definition of health care provider including mental health practitioners licensed by behavioral sciences regulatory board.	No Action	No Action
HB 2243	The use of tobacco in medical care facility or on medical care facility property.	No Action	No Action
HB 2247	Home plus beds, nursing facilities.	No Action	No Action
HB 2252	Human cloning, criminal and civil penalties.	No Action	No Action
HB 2254	Crimes concerning human embryos.	No Action	No Action
HB 2255	Human cloning, prohibiting certain expenditures of moneys appropriated from the state treasury by state agencies.	2/13/07	2/20/07, Passed Favorably As Amended
HB 2265	Nonmedical services of occupational therapists.	No Action	No Action
HB 2266	Umbilical cord donation information act.	3/8/05	No Action
HB 2271	Prescribing disclosure and availability of health care quality and performance indicators.	No Action	No Action
HB 2292	Abortion; performance on a minor; certain restrictions. Recommend interim study.	3/6/07, 3/14/07	No Action
HB 2312	When an autopsy is performed a test for levels of phenylalanine in the dead body is to be made.	No Action	No Action
HB 2327	Establishing the applied behavioral science training program with an emphasis on autism spectrum disorders.	No Action	No Action
HB 2342	Hospital infections disclosure act.	No Action	No Action
HB 2351	Kansas mental health parity act, coverage.	No Action	No Action
HB 2355	Department of health and environment, food service and lodging act, licensure and inspection of lodging establishments, fees, fee funds.	No Action	No Action
HB 2376	Treatment facilities and programs not to include behavioral sciences regulatory board licensees or board of healing arts licensees.	No Action	No Action
HB 2392	Registration requirements of pharmacy for wholesale distribution of drugs.	2/14/07	No Action
HB 2401	Healthy workplace act; abusive workplace environments.	No Action	No Action
HB 2414	Unlawful sale of liquid, capsule or gel capsule ephedrine to minors; placement behind store counters.	No Action	No Action
HB 2416	Prescription program model act.	No Action	No Action
HB 2417	Membership on the Kansas dental board.	No Action	No Action
HB 2418	General hospital defined.	2/15/07	2/20/07, Passed Favorably
HB 2444	Background checks on certain persons at child care facilities and family day care homes	No Action	No Action

HB 2454	Abortions; informed consent; performance of sonograms in certain cases.	No Action	No Action
HB 2472	Interpreters data bank.	No Action	No Action
HB 2481	Persons authorized to make adoption assessments.	No Action	No Action
HB 2482	Deaths which are ruled suicides; investigation reports and suicide notes, if any, available to the immediate family; family may view the scene.	No Action	No Action
HB 2483	Physical therapists evaluation and treatment of patients.	2/15/07	2/20/07, Passed favorably as amended
HB 2503	Child support enforcement; insurance and workers comp payments; perfection of liens; unlawful acts. Recommend for study in Interim Session	3/8/07, 3/21/07	No Action
HB 2531	Pharmacy act amendments concerning durable medical equipment and wholesale drug distribution regulation.	3/5/07, 3/21/07	3/12/07, 3/13/07, 3/21/07, Passed favorably as amended
HB 2570	Persons authorized to make adoption assessments.	No Action	No Action
HB 2578	Establishing the utilization of unused medications act.	No Action	No Action
HB 5011	Urging the United States Congress to reauthorize the State Children Health Insurance Program (SCHIP) and urging Governor Sebelius to assist enrollment of children qualifying for Medicaid or HealthWave.	No Action	No Action
HB 6006	Resolution urging the governor and University of Kansas medical center to not enter any affiliation without legislative review.	2/7/07	No Action
SB 62	Restrictions on prescribing, ordering, dispensing, administering, selling, supplying or giving certain amphetamine or sympathomimetic amine controlled substances.	3/1/07	3/1/07, Passed favorably
SB 63	Limitations on filling prescriptions	3/1/07	3/1/07, Passed favorably
SB 72	Concerning mortuary arts, defining funeral director; grounds for revocation, denial, suspension or conditioning of licenses.	3/1/07	3/1/07, Passed favorably as amended
SB 81	Fingerprinting and criminal history background checks required by the board of healing arts.	3/1/07	No Action
SB 82	Sub for S 82 by Committee on Public Health and Welfare -- Healing arts school and general corporation; exceptions to the prohibited practice of healing arts.	3/7/07	3/13/07, Passed favorably, placed on Consent Calendar
SB 104	The board of nursing; membership thereon; amending K.S.A. 74-1106 and repealing the existing section.	3/7/07	3/21/07, Passed favorably as amended
SB 105	Renewal of authorizations to practice for persons regulated by the board of nursing.	3/7/07	3/21/07, Passed favorably
SB 106	Deletion of exemption from nurse practices act for graduates of nursing schools.	3/7/07	3/21/07, Passed favorably
SB 107	Fingerprinting and criminal history background checks for certain licensees of the board of nursing.	No Action	No Action
SB 138	Autism task force.	3/7/07	3/22/07, Passed favorably as amended
SB 176	Dental hygienists; issuance of permits, authorized practice.	3/12/07	3/21/07, Passed favorably
SB 178	Cancer registry; uses of confidential data.	3/14/07	3/14/07, Passed favorably
SB 179	Requiring high school graduation or equivalent for application for assistant funeral director.	3/14/07	3/21/07, Passed favorably
SB 201	Child placement agencies; secretary of health and environment; information on persons at child care facilities or family day care homes.	3/20/07 3/21/07	3/22/07, Passed favorably

SB 202	Definition of child care facility.	3/14/07	3/14/07, Passed favorably
SB 284	Radiologic technologist licensure requirements.	3/6/07	3/21/07, Passed favorably as amended
SB 285	Billing for anatomic pathology services as grounds for unprofessional conduct by the board of healing arts.	3/13/07	3/13/07, Passed favorably
SB 323	Kansas health policy authority; Medicaid reimbursement.	No Action	No Action
SB 328	Professional corporations, allowing licensed audiologists to form.	3/22/07	3/22/07, Passed favorably as amended

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BILL NUMBER	SUBJECT	DATE OF HEARING/ DISCUSSION	DATE OF FINAL ACTION BY FULL COMMITTEE
HB 2224	KDHE, certain genetic diseases and disorders, education and newborn screening program, assistance	No Action	No Action
HB 2235	Board of nursing fees.	2/25/08	2/25/08 Bill Failed
HB 2239	Health care providers, risk management, definition of health care provider including mental health practitioners licensed by behavioral sciences regulatory board.	No Action	No Action
HB 2243	The use of tobacco in medical care facility or on medical care facility property.	No Action	No Action
HB 2247	Home plus beds, nursing facilities.	No Action	No Action
HB 2252	Human cloning, criminal and civil penalties.	No Action	No Action
HB 2254	Crimes concerning human embryos.	No Action	No Action
HB 2265	Nonmedical services of occupational therapists.	No Action	No Action
HB 2266	Umbilical Cord donation information act.	2/28/07	No Action
HB 2271	Prescribing disclosure and availability of health care quality and performance indicators.	No Action	No Action
HB 2292	Abortion; performance on a minor; certain restrictions. Recommend interim study.	3/6/07, 3/14/07	No Action
HB 2312	When an autopsy is performed a test for levels of phenylalanine in the dead body is to be made.	No Action	No Action
HB 2327	Establishing the applied behavioral science training program with an emphasis on autism spectrum disorders.	No Action	No Action
HB 2342	Hospital infections disclosure act.	No Action	No Action
HB 2351	Kansas mental health parity act, coverage.	No Action	No Action
HB 2355	Department of health and environment, food service and lodging act, licensure and inspection of lodging establishments, fees, fee funds.	No Action	No Action
HB 2376	Treatment facilities and programs not to include behavioral sciences regulatory board licensees or board of healing arts licensees.	No Action	No Action
HB 2392	Registration requirements of pharmacy for wholesale distribution of drugs	2/14/07	No Action
HB 2401	Healthy workplace act; abusive workplace environments.	No Action	No Action
HB 2414	Unlawful sale of liquid, capsule or gel capsule ephedrine to minors; placement behind store counters.	No Action	No Action
HB 2416	Prescription program model act.	No Action	No Action
HB 2417	Membership on the Kansas dental board.	No Action	No Action
HB 2444	Background checks on certain persons at child care facilities and family day care homes	No Action	No Action
HB 2454	Abortions; informed consent; performance of sonograms in certain cases.	No Action	No Action

HB 2472	Interpreters' data bank.	No Action	No Action
HB 2481	Persons authorized to make adoption assessments.	No Action	Combined into H2570
HB 2482	Deaths which are ruled suicides; investigation reports and suicide notes, if any, available to the immediate family; family may view the scene.	No Action	No Action
HB 2503	Child support enforcement; insurance and workers comp payments; perfection of liens; unlawful acts. Recommend for study in Interim Session	3/8/07, 3/19/07	Recommend Interim study 3/21/07
HB 2570	Persons authorized to make adoption assessments.	2/7/08, 2/19/08	2/20/08, Passed favorably as amended
HB 2607	School districts; healthy weight programs; state grants	No Action	No Action
HB 2620	State board of healing arts, non-disciplinary resolutions	3/17/08	No Action
HB 2650	Controlled substances; salvia divinorum.	2/12/08	No Action
HB 2666	Liens for hospitals and ambulatory surgical centers	No Action	No Action
HB 2672	Long-term care units, inspection by Department On Aging	2/4/08	2/25/08, Passed favorably as amended
HB 2695	Athletic Trainer Licensure	2/12/08	2/20/08, Passed favorably as amended
HB 2702	Excepted acts and reciprocity concerning the practice of dentistry.	2/25/08, 2/27/08	2/25/08, Passed favorably as amended Consent Calendar
HB 2721	Board of cosmetology; licensing requirements	2/20/08	2/21/08, Passed favorably as amended
HB 2781	Dental offices; permitting additional offices in counties with low population densities	2/19/08	2/19/08, Passed favorably as amended
HB 2810	Optometrists dispensing optthalmic lenses	No Action	No Action
HB 2846	Medical facilities; patient safety	No Action	No Action
HB 2855	Cleaning Process used by certain launderies	2/20/08	No Action
HB 2906	Family and medical leave insurance, establishing task force	No Action	No Action
HB 2907	Prescription Drugs; epilepsy and seizures	No Action	No Action
HB 2914	Enacting the pharmaceutical manufacturing company disclosure act	3/17/08	No Action
HB 2934	Health care reform act of 2008	2/27/08, 3/13/08	Bill passed amended, 3/14/08 S sub 81 passed over and retain a place on calendar
HB 2975	An act concerning insurance; tax credits	No Action	No Action
HB 5011	Urging the United States Congress to reauthorize the State Children Health Insurance Program (SCHIP) and urging Governor Sebelius to assist enrollment of children qualifying for Medicaid or HealthWave.	No Action	No Action
H Sub SB81	The Health Care Reform Act of 2008	3/14/08, 3/17/08	From H2934 Sub Bill Passed Amended, 3/14/08
SB 81	Fingerprinting and criminal history background checks required by the board of healing arts.	3/1/07	No Action
SB 107	Fingerprinting and criminal history background checks for certain licensees of the board of nursing.	3/17/08	No Action
SB 323	KHPA; Medicaid reimbursement.	No Action	No Action
SB 346	Creating the KS long-term care bill of rights	No Action	No Action
SB 481	Controlled substance, schedule I, salvia and gypsum weed.	2/12/08	No Action
S Sub 491	Sub for S 491 by Committee on Public Health and Welfare -Prescription monitoring program act.	3/24/08	3/25/08, Passed favorably as amended
SB 512	Emergency medical services, attendant's certificate requirements	3/17/08	3/25/08, Passed favorably as amended
SB 529	Educational awareness regarding meningococcal meningitis vaccine.	3/18/08	No Action

SB 540	Health insurance; Kansas small business health policy committee act health insurance clearinghouse, age of dependents, very small employers	3/13/08	No Action
SB 541	Powers and duties of the Kansas Health Policy Authority; relating to a medical home, premium assistance and small business wellness grant program; establishing a health reform fund	3/13/08	No Action
SB 548	School-based influenza vaccination pilot program.	3/18/08	No Action
S Sub 549	Sub for S 549 by Committee on Public Health and Welfare -- Board of pharmacy; continuous quality improvement programs and nonresident pharmacy.	3/24/08	3/25/08, Passed favorably as amended
S Sub 596	Sub for S 596 by Committee on Public Health and Welfare -- Board of healing arts; cosmetic or aesthetic purpose included in the practice	3/18/08	3/25/08, Passed favorably as amended

Joint Committee on Health Policy Oversight

The Joint Committee on Health Policy Oversight was established by the 2005 House Substitute for SB 272, the legislation which created the Kansas Health Policy Authority and the Joint Oversight Committee. As set forth in House Substitute for SB 272, 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. Committee members serve two year terms, while the Chairperson and Vice Chairperson serve one-year terms alternately appointed by the House Speaker and Senate President. Legislation allows the committee to meet at any time on call of the Chairperson and the committee is subject to the provisions applicable to special committees, such as the filing of an annual report and the ability to introduce legislation as it deems necessary.

The first meeting of the committee was held on September 9, 2005. The committee was chaired by Representative Melvin Neufeld with Vice Chairperson Senator James Barnett in 2005, 2006, and 2008. Ten other members, including five each from the House and Senate take part in the proceedings. In 2007, Senator Barnett chaired the committee and Representative Neufeld served as Vice Chairperson.

The Joint Committee meets mostly in the interim session to discuss matters relevant to the Health Policy Authority. The following is a timeline and summary of the committee's work, compiled from the annual reports of the Joint Committee to the full legislature.

2005

In 2005 the Joint Committee met three times. The meetings were mostly informational, discussing strategies that might be employed by the KHPA to comply with its charge. The Joint Committee heard testimony on the interim transfer of health-related programs from the Kansas Department of Social and Rehabilitation Services to the newly-created Division of Health Policy and Finance within the Kansas Department of Administration. Additionally, representatives from the health community provided information on a range of topics, such as the availability of health data, community health projects, health care costs and the health insurance industry, and cost containment initiatives. The committee report stated the Joint Committee's commitment to

remaining focused on the overall goal of improving the health of Kansans. The Committee Report concluded the Joint Committee's oversight of the Authority in the future will focus on the following responsibilities:

- Developing and maintaining a coordinated health policy agenda that combines effective purchasing and administration of health care with health promotion oriented public health strategies;
- Submitting to the 2007 Legislature, and annually thereafter, a report to include recommendation for implementation of the health policy agenda. The annual report shall include health indicators developed by or adopted by the Health Policy Authority and baseline and trend data on the health costs and indicators;
- Assuming the function of the Health Care Data Governing Board and Kansas Business Health Partnership on January 1, 2006;
- Submitting a plan and recommendations for funding and any recommended legislation for the transfer of the powers, duties and functions of the Division of Health Policy and Finance on July 1, 2006;
- Assuming the operational and purchasing responsibilities from the Division of Health Policy and Finance from the regular medical portion of the State Medicaid program; MediKan program; the State Children's Health Insurance program; the Working Healthy program; the Medicaid Management Information System; the Drug Utilization Review program; the State Health Care Benefits program; and the State Workers Compensation program on July 1, 2006;
- Submitting to the 2007 Legislature recommendations and an implementation plan for the transfer of additional Medicaid-funded programs;
- Submitting to the 2008 Legislature recommendations and an implementation plan to assume responsibility for health care purchasing functions within additional state agencies³.

No legislation was proposed by the committee to the 2006 Legislature.

2006

During the 2006 calendar year, the Joint Committee focused on monitoring the Activities of the KHPA and ensuring that the Authority worked independently to meet its statutory responsibilities. Specifically, the committee paid close attention to the transfer of programs from the Department of Administration's Division of Health Policy and Finance to the Authority. The committee heard updates from the Authority on the organization of the Health Policy Authority Board, the Authority vision principles, staffing and personnel changes, and program updates and initiatives. Health policy issues such as the health status of Kansans, health disparities, health system reform, and price and quality of care transparency. Several public health experts gave testimony on these issues and provided recommendations for the KHPA as they move forward with health reform in Kansas. The Committee Report concluded with the following challenges for the Authority:

- Continue to focus its efforts on ensuring that all health programs in Kansas are working together to improve the health of Kansans and that the health model for Kansas shifts from health care to health wellness;
- Encourage prevention policies and programs that encompass all age groups; that include prenatal care; and that include all service providers who impact, directly and indirectly, the health of Kansans;

³ Report of the Joint Committee on Health Policy Oversight to the 2006 Kansas Legislature.

- Continue to develop the coordinated statewide health policy agenda that combines the effective purchasing and administration of health care with health promotion oriented public health strategies;
- Identify new innovative ways to address health care policy;
- Consider cost containment issues and strategies when reviewing Kansas health policy;
- Encourage personal accountability regarding health insurance;
- Track the implementation of health care programs to ensure that expectations are being met;
- Encourage the implementation of “e-prescribe” as soon as the health care system can accommodate the technology;
- Make the provision of dental care a priority goal, particularly for Medicaid recipients, the uninsured, and underinsured;
- Work with the state’s federal delegation on important health policy issues; and
- Continue to submit requests for assistance to the Committee, including the introduction of legislations, as needed to meet its statutory responsibilities⁴.

No legislation was proposed by the committee to the 2007 Legislature.

2007

The Joint Committee met four times in the 2007 Interim. In addition to the traditional oversight of the Authority, the Legislative Coordinating Council also assigned the Joint Committee to study the presumptive disability process which was implemented in 2006. The Joint Committee reviewed the new process and its effects on vulnerable populations of Kansans. However, much of the Joint Committee’s focus centered on the implementation of 21 health reform measures recommended by the Authority. After updates on the Medicaid program the committee heard testimony on the recommendation development process, including the involvement of input received from the Authority Board, advisory councils, and statewide listening tour. The Authority considered three priorities in designing the 21 recommendations: Promote personal responsibility for health, offer initiatives related to prevention and medical homes, and provide and protect affordable health insurance. The Joint Committee discussed the costs associated with implementing the reforms.

The Joint Committee also received information on the health reform directives contained in SB 11 and other health-related topics. The directives in SB 11 included topics such as premium assistance, the impact of extending continuation benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA) and other policies designed to make insurance more affordable, the newly-created Office of the Inspector General, safety-net clinics and others. Additional topics included updates on health system reforms in other states, prescription drug diversion, and the Kansas Association of Health Underwriters.

The 2007 report concluded with the Joint Committee’s decision to support and adopt for consideration by the 2008 Legislature the 21 health reform recommendations offered by the KHPA. The Joint Committee directed that those health reform recommendations that require implementing legislation be drafted as bills⁵.

2008

⁴ Report of the Health Policy Oversight to the 2007 Kansas Legislature.

⁵ Report of the Joint Committee on Health Policy Oversight to the 2008 Kansas Legislature.

To date, the 2008 report of the Joint Committee has not yet been completed. The Joint Committee held three, one-day meetings during the 2008 Interim and the following summary is compiled from the agendas and meeting minutes.

The Joint Committee began by looking at a number of health reform issues. The committee heard testimony on the wages and benefits for direct care workers from variety of interested organizations and reviewed the report of the Post Audit Committee on this topic. Required studies on bariatric surgery for the morbidly obese and the state high risk pool were presented to the Joint Committee as well as a report on the status of remaining studies to be completed by the Authority as directed by the Legislative Coordinating Council. The Joint Committee also spent some time looking at the issue of chronic care management. The Authority gave an overview of current state initiatives and the committee heard testimony from representatives from the Asheville Project.

Additionally, the KHPA presented testimony to the Joint Committee on a number of initiatives the agency is involved in. The Authority presented testimony on their 2009 health reform recommendations and discussed the Medicaid Transformation Plan Recommendations and how they will be implemented into the state Medicaid program. The Authority also updated the committee on the activities of the Data Consortium and its progress.

Subject Gap Analysis

Analysis of the subject of bills by title yielded fourteen subject categories and a number of bills with miscellaneous subjects. In an effort to give a clear picture of the topics covered by each committee, the following table shows the number of bills in each category introduced in the three standing health committees between 2005 and 2008. Bills leftover in committee in a subsequent year were counted only for the year they were first introduced.

SUBJECT	SENATE HEALTH CARE STRATEGIES	SENATE PUBLIC HEALTH AND WELFARE	HOUSE HEALTH AND HUMAN SERVICES
Abortion	0	3	5
Daycare and Child Care Workers	0	4	6
Federal Issues	1	0	2
Health Insurance	0	2	5
Health Reform	2	2	10
Hospitals	1	3	4
KHPA	3	1	1
Legal	0	0	6
Prescription Drugs and Pharmacies	1	12	21
Professional Boards and Licensing	1	37	61
Public Health	0	17	24
Schools	0	7	11
Social Services	0	10	14
Miscellaneous	0	9	8

Conclusions

Analysis of the issues discussed by the existing health committees suggests that an additional standing committee to deal with the future of health care and health reform does not appear to be necessary at this time. It is assumed that the proposed health futures committee would hear bills relating to health system reform, public health issues, Medicaid reform, health cost containment, access, and health care workforce issues. These are issues which the current standing health committees and the Joint Committee on Health Policy Oversight are already examining in detail. Moreover because the KHPA has a Joint Oversight Committee which meets off-session, the KHPA staff and Board are able to work directly with legislators between legislative sessions.