Approved: Feb. 10, 1998
Date

MINUTES OF THE Senate Committee on Financial Institutions and Insurance.

The meeting was called to order by Chairperson Don Steffes at 9:00 a.m. on January 27 , 1998 in Room 529-S of the Capitol.

All members attending except:

Others attending: See attached list

Committee staff present: Dr. William Wolff, Legislative Research Department
Fred Carman, Revisor of Statutes
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee: Mary Ellen O'Brien Wright
Ann Koci, SRS
Tom Wilder, Kansas Insurance Department
Representative Melvin Neufeld

Mary Ellen O'Brien Wright, Assistive Technology for Kansans, requested the introduction of legislation which would require health insurance companies to provide a minimum of $10,000 annually for prescribed durable medical equipment (Attachment 1).

Senator Praeger moved for the introduction of the proposal into legislation. Motion was seconded by Senator Barone. Motion carried.

Briefing on SB 424--Kansas insurance coverage for kids

Senator Praeger announced that leadership had established a Task Force on Childrens Health Insurance Program made up of senators, representatives, executive branch representatives, and staff from legislative research and the revisor of statute's office (Attachment 2). She explained the funding process and the option to amend the plan at any time after it is submitted to the federal government. Representative Melvin Neufeld reported on the four meetings which have been held thus far between the Secretary of SRS, representatives from the Adult Medical Services branch, and legislative appointees.

Ann Koci, SRS, presented proposed amendments and changes to the bill (Attachment 3). She reviewed the basic program designs, eligibility levels, enrollment, administration, allotments, financing and maintenance of effort (Attachment 4). Ms. Koci informed the committee that legislation was not needed to implement the bill and the way of funding can ben changed according to the annual budget. This method would abolish the stair-stepping eligibility as HCFA will not allow the states to roll anyone back. This will not expand the state into more entitlements. They anticipate 60,000 children will be enrolled in the ten year program. The current computer system in the state can handle this extra load. Federal funding will be approximately $30 million with Kansas matching funds of $10 to $12 million. Mechanisms would be in place to ensure that children who are eligible for regular insurance or medicaid are not placed on the program. The children placed on the program must have been without insurance for at least six months. Ten percent of the total expenditures of the program can be used for outreach enrollment and administration costs, presumptive eligibility can be part of the plan, and seamless coverage would mean 12 month continuous eligibility for the children in question. The bill becomes effective September 30, 1998.

Tom Wilder, Kansas Insurance Department, reviewed the major provisions of the act regarding expenditure of funds, administration of the program, level of benefits, and suggested medicaid be set at 150% of poverty level (Attachment 5). Mr. Wilder urged the committee to act quickly and responsibly in the adoption of this program, not attempt to micromanage the program but rather allow the experts to have oversight, and allow the persons involved with the implementation to manage the program. He also encouraged the members not to become "hung up" on the language of the bill. The states plan to handle information regarding the blending of the insurance and medicare programs as well as implementation of the programs through regional meetings and the establishment of groups monitoring the progress of the insurance program for children.

Representative Neufeld reported that this was one of the major issues of the session. He urged the Committee to be aware of the percentage of medicare we must match.

The meeting was adjourned at 10:00 a.m. The next meeting is scheduled for January 28, 1998.

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 1-27-98

NAME	REPRESENTING
Mary Draper	Ks Medical Society
Susan anderson	Hein + Weir
Sally Finney	Kansas Public Health Association
Robin Lichman	Kansas Action for Children
Josie Torrez	Families Together, Inc.
Rebecca Rice	KS Chiropractic Assn.
Mika Meacham	
Bob Harder	MPS
Larry Pitman	KFMC
mary Ellen O'Brien Knight	assoc. Tech. for Kansans
John Wunsch	KC Star
Rochelle Chronister	SRS
John Garlinger	SRS
Ann Koci	SRS
Larry Tobias	KS. Hosp. Assn.
Gary Pedersen	Bayer
Sister Therese Bangert	Kansas Catholic Conference
Michelle Peterson	PhRMA
David Scott	Ks Families for Kids

Assistive
Technology
For
Kansans

A Project
Coordinated by the
University of Kansas
At Parsons

For Statewide
Information and
Referral Phone
800-526-3648
(Voice)
800-500-1034
(TTY)

Assistive Technology for Kansans
Introduction
Durable Medical Equipment Bill
January 27,1998

My name is Mary Ellen O'Brien Wright, and I am with Assistive Technology for Kansans, a program whose primary purpose is to ensure that children and adults with disabilities in Kansas have improved and increased access to assistive technology and related services. This proposed bill would require health insurance companies to provide a minimum of $10,000 annually for prescribed DME. The bill also requires health insurance companies to purchase power equipment, such as wheelchairs, when a physician prescribes such equipment.

People with disabilities have brought it to our attention that the Durable Medical Equipment (DME) coverage provided by health insurance companies can be inadequate and prove a financial hardship for an individual with a disability, or families with a child with a disability. A number of disability organizations are in favor of passage of this bill, including Families Together, the Kansas Association of Centers for Independent Living, the Kansas Council On Developmental Disabilities, and the Statewide Independent Living Council of Kansas.

Attachment 1
Senate FI+D 1-27-98

Advisory Memorandum

TO: All Kansas Legislators
Governor Graves
Statehouse Media

FROM: Senate President Dick Bond
Senate Minority Leader Anthony Hensley
Speaker of the House Tim Shallenburger
House Minority Leader Tom Sawyer

DATE: January 26, 1998

RE: Task Force on Childrens Health Insurance Program

****

We are announcing the formation of a Task Force on the Childrens Health Insurance Program. The purpose of this task force is to produce legislative language for a health insurance plan that will enable Kansas to insure more children by taking advantage of matching federal funds. The task force is made up of majority and minority members of both houses, along with representatives of the executive branch and staff from Research and the Revisor of Statutes office.

Following is the membership:

Sen. Sandy Praeger (co-chair)
Sen. Karin Brownlee
Sen. Paul Feleciano, Jr.
Sen. Chris Steineger
Sen. Larry Salmans

Rep. Melvin Neufeld (co-chair)
Rep. Henry Helgerson, Jr.
Rep. Brenda Landwehr
Rep. Carlos Mayans
Rep. Jerry Henry

Executive Branch Representatives
Gloria Timmer
Ann Koci, SRS
Danielle Noe, Governor's Office
Tom Wilder, Insurance Department

Staff
Emalene Correll
Norman Furse
Bill Wolff
Robin Kempf

Senate FSB
Attachment 2
~~2/4/98~~ 1-27-98

State of Kansas
Department of Social & Rehabilitation Services

Rochelle Chronister, Secretary
Janet Schalansky, Deputy Secretary

For additional information, contact:

SRS Office of Research
Suzanne Woods, Director
915 SW Harrison Street, Sixth Floor
Topeka, Kansas 66612-1570
☎785.296.3329 / Fax 785.296.4685

For fiscal information, contact:

SRS Finance Office
Diane Duffy, CFO
915 SW Harrison Street, Tenth Floor
Topeka, Kansas 66612-1570
☎785.296.6216 / Fax 785.296.4676

Financial Institutions and Insurance Committee
Tuesday, January 27, 1998

Testimony: SB 424 - Kansas Insurance Coverage for Kids

Adult and Medical Services Commission
Ann Koci, Commissioner
296-5217

Senate FI & I
Attachment 3
1-27-98

Mr. Chairman and members of the committee, I am Ann Koci, Commissioner of Adult and Medical Services. Thank you for the opportunity to testify on behalf of Secretary Chronister today on Senate Bill No. 424. We appreciate the chance to clarify three key issues through the attached ballooned bill.

First, on line fifteen and line sixteen the phrase "which shall be known as Kansas insurance coverage for kids," should be deleted. This phrase should not be defined in statue. Federal law allows for and the executive task force recommended the hiring of a private marketing firm to develop a name and logo for the state childrens health insurance program.

Secondly, on line nineteen the phrase "zero to 18 years," needs to be clarified. Federal law allows for coverage through the age of eighteen which is up to the age of nineteen.

Thirdly, section (e) needs to be clarified. The state childrens health insurance program is not an entitlement above the highest poverty line established in above sections (b)(1) and (2) of this bill.

(Corrected)

Session of 1998

SENATE BILL No. 424

By Health Care Reform Legislative Oversight

1-13

AN ACT relating to Kansas insurance coverage for kids; secretary of social and rehabilitation services' duties.

Be it enacted by the Legislature of the State of Kansas:

Section 1. (a) The secretary of social and rehabilitation services shall develop and submit a plan consistent with federal guidelines established under section 4901 of public law 105-33 (42 U.S.C. 1397aa *et seq.*) ~~which shall be known as Kansas insurance coverage for kids~~.

(b) The plan developed in subsection (a) and amendments thereto shall be a capitated managed care plan covering Kansas children ~~ages zero to 18 years~~ which:

(1) Raises the eligibility requirements for medicaid to a level set by the secretary consistent with the federal guidelines;

(2) does away with the three existing levels of medicaid eligibility;

(3) classifies all covered children as one group with no distinction between their funding source; and

(4) contains benefit levels equal to those for the early and periodic screening, diagnosis and treatment plan currently existing under medicaid.

(c) The secretary is authorized to contract with managed care insurers to implement the coverage plan in section 1 and amendments thereto.

(d) As family income increases, a child shall remain in the ~~Kansas insurance coverage for kids group~~ with the secretary developing a plan for a parent or guardian to pay a portion of the premium.

(e) The ~~Kansas insurance coverage for kids plan~~ is not an entitlement program. Waiting lists to enter the program may develop based upon availability of funds.

Sec. 2. This act shall take effect and be in force from and after its publication in the statute book.

, the State childrens health insurance program.

0 through 18 years of age.

State childrens health insurance program.

above eligibility as determined from items (b)(1) and (2).

State of Kansas
Department of Social & Rehabilitation Services

Rochelle Chronister, Secretary
Janet Schalansky, Deputy Secretary

For additional information, contact:

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Financial Institutions and Insurance Committee
January 27, 1998

Testimony: Children's Health Initiative

Adult and Medical Services
Ann Koci, Commissioner
296-5217

Senate FI&I
Attachment 4
1/27/98

STATE OF KANSAS

BILL GRAVES, *Governor*
State Capitol, 2nd Floor
Topeka, Kansas 66612-1590

(913) 296-3232
1-800-432-2487

FAX: (913) 296-7973

OFFICE OF THE GOVERNOR

MEMORANDUM

TO: HHS Bi-Regional Conference Participants

FROM: Danielle Noe, Legislative Liaison

DATE: December 22, 1997

SUBJECT: Children's Health Insurance Program

Thank you for the opportunity to update you on Kansas' plans for the Children's Health Insurance Program. At this time, Kansas is continuing to seek advice about the best way to provide insurance coverage to the estimated 60,000 children who are eligible for Title XXI benefits.

Like other states, Kansas has received much input on this program. Last fall, two different task forces began to study the issue. Together. they made a recommendation which includes a Medicaid expansion with the possibility of private sector initiatives.

The Governor is particularly interested in obtaining more information about potential private partnerships. He expects to have enough information to make a recommendation to the Legislature in early to mid January

Presented by Debbie Chang, Director
Office of Legislation, Health Care Financing Administration
Co-Chair, U.S. Department of Health and Human Services CHIP Steering Committee

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

- **BASIC PROGRAM DESIGN**
- **SETTING ELIGIBILITY LEVELS**
- **ALLOTMENTS**
- **OUTREACH/ENROLLMENT AND ADMINISTRATION**
- **FINANCING AND MAINTENANCE OF EFFORT**

BASIC PROGRAM DESIGN

- **States can choose to provide child health assistance to low-income, uninsured children through:**
  - **a separate insurance program;**
  - **a Medicaid expansion; or**
  - **a combination of these two approaches.**

BASIC PROGRAM DESIGN

- **For States that choose a separate program, they have four benefit options:**
  - **benchmark coverage (BCBS PPO, HMO, State employee plan);**
  - **benchmark-equivalent coverage;**
  - **existing comprehensive State-Based coverage (FL, NY, PA); and**
  - **Secretary-approved coverage.**

BASIC PROGRAM DESIGN

*Separate program continued

- **Cost-Sharing:**
  - **At or below 150% of poverty, it must be at Medicaid medically needy levels (inflation adjustment permitted for cost-sharing);**
  - **Above 150% of poverty, it cannot exceed 5% of family income for all children in the family;**
  - **No cost-sharing is permitted for well-baby, well-child care, including immunizations.**
  - **Cannot favor higher-income children over lower-income children.**

BASIC PROGRAM DESIGN

- For States that choose to expand Medicaid, they must:
  - use full Medicaid benefits; Can the healthy
  - meet all Medicaid rules; and
  - comply with Medicaid cost-sharing rules (i.e., no cost-sharing for children).

SETTING ELIGIBILITY LEVELS

- A "targeted low income child" is one who:
  - meets the State eligibility standards;
  - has a family income at or below 200% of poverty or 50% points above Medicaid limit;
  - is not eligible for Medicaid or other insurance (except State-only coverage in effect 7/1/97);
  - is not an inmate of a public institution; - children in juvenile detention
  - is not a patient in an IMD; and others are not eligible
  - is not in a family eligible for State employee health plan.

150- 160,000 Managed care
Capitated system

SETTING ELIGIBILITY LEVELS

- For States that choose Medicaid, the following categories can be a "targeted low-income child:"
  - child receiving inpatient psychiatric care; and
  - child in a family eligible for a State employee health plan.
- States that choose to accelerate coverage of 15 through 18 year olds under 100% of poverty will get enhanced match (until they age in).

SETTING ELIGIBILITY LIMITS

- Immigrants: Under an 8/97 proposed rule, legal immigrant children who arrive after 8/22/96 will not be eligible for 5 years. States may cover those who arrive before 8/22/96. Under Medicaid, undocumented persons can only receive emergency care.
- Native Americans: Non-duplication rules do not apply to IHS programs.
- Crowd out: States must describe how this does not substitute for group coverage.

OUTREACH/ENROLLMENT AND ADMINISTRATION

- New options under the BBA:
  - Presumptive eligibility for children;
  - 12 month continuous eligibility for children
- Current authority to conduct outreach:
  - shortened and simplified eligibility forms;
  - combined form for both Medicaid and CHIP;
  - outstationing eligibility workers

OUTREACH/ENROLLMENT AND ADMINISTRATION

- Under CHIP, 10 percent of Federal expenditures may be used for total costs of:
  - outreach;
  - administration;
  - direct services to children; and
  - other child health assistance.
- The Secretary may waive the 10 % limit for coverage that is cost-effective and is provided through a community-based health delivery system.

ALLOTMENTS

- A State must have an approved State plan for the Federal fiscal year (FY) in order to receive an allotment that year.
  - For example, to receive an allotment for a FY98, a State must have an approved plan by 9/30/98.
- The child health plan is not required to use the full allotment in a FY. Allotments are available to States for up to 3 years.

FINANCING AND MAINTENANCE OF EFFORT

- States will receive enhanced match for child health assistance.
  - For States that create a separate program, Federal funds, premiums and other cost-sharing cannot be used for the State matching requirements.
  - Medicaid provider taxes and donations rules apply.
  - Intergovernmental transfers can be used for State matching requirements.

FINANCING AND MAINTENANCE OF EFFORT

- Maintenance of effort rules:
  - States cannot adopt more restrictive income and resource standards and methodologies for Medicaid than those in effect on 6/1/97.
  - New York, Pennsylvania and Florida must maintain State children's health spending at least at the 1996 levels.

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

ROCHELLE CHRONISTER, SECRETARY

Adult and Medical Services Commission
Docking State Office Bldg., Rm. 628-S
Topeka, KS 66612
Telephone: (785) 296-5217
Fax: (785) 296-4813

January 27, 1998

Dear Financial Institution and Insurance Committee Members:

While attending a managed care conference, I was fortunate to meet Stephen Somers, Director of Center for Health Care Strategies. One of the break out sessions at the conference spoke to the needs and challenges of State Medicaid agencies regarding managed care.

Following the session, I had the opportunity to speak with Mr. Somers on specific issues related to Kansas. The outcome was a request from Mr. Somers for Kansas to be the first state to participate in a managed care "Readiness Assessment" conducted by a team from the Center. We gladly accepted. In February 1997 we started the assessment. Among several issues identified, the key one focused on the need for an independent evaluation of the adequacy and/or inadequacy of Kansas rates.

Based on its readiness assessment, the Center agreed to provide Kansas Medicaid with technical assistance, through a grant, to compare the Kansas Medicaid rates to those of other payers. The Center subcontracted with Jim Verdier, Mathematica Policy Research, Inc. to assess the Medicaid physician reimbursement fee schedule, its relationship to managed care and options for changing the fee schedule.

Mr. Verdier's assessment is attached. It is important to note that this study is the first step towards the review of Medicaid rates. It is based on approximately 600 procedure codes for physician reimbursement. In addition, because hospital outpatient reimbursement in Kansas is tied to the physician fee schedule, revision would impact outpatient reimbursement as well.

Sincerely,

Ann E. Koci

Ann E. Koci
Commissioner

AEK:mv

Att.

4-10

MATHEMATICA
Policy Research, Inc.

James M. Verdier
Director of State Health Policy

600 Maryland Ave. S.W., Suite 550
Washington, DC 20024-2512
TEL (202) 484-9220
FAX (202) 863-1763

DIRECT (202) 484-4520

January 8, 1998

Ann Koci
Commissioner of Adult and Medical Services
Department of Social and Rehabilitation Services
915 SW Harrison, Room 628-S
Topeka, KS 66612

Dear Commissioner Koci:

This letter summarizes the issues we have discussed regarding the Medicaid physician reimbursement fee schedule, its relationship to managed care, and options for changing the fee schedule.

SUMMARY

In the aggregate, Medicaid physician reimbursement in Kansas is substantially below that of most state Medicaid programs, Medicare, and private insurance. Kansas rates are especially low for many primary care services, such as hospital and office visits and immunizations. The rates are substantially above average, however, for many lab, x-ray, and surgical services, and for maternity care. While HMOs are not required to use the Medicaid physician fee schedule to reimburse physicians, many of them do. Further, HMO capitated rates derived from the low Medicaid fee schedule may not be sufficient to induce participation in the Medicaid program by as many experienced and capable HMOs as the state would like. Thus, revising the fee schedule to increase reimbursement for primary care physician services could increase access to this kind of care in both the fee-for-service and managed care portions of the Kansas Medicaid program.

The cost of increasing rates for primary care services could be offset by reducing physician fees in other parts of the fee schedule where Kansas rates are substantially above the average of other state Medicaid programs, such as labs, x-rays, surgeries, and maternity care. Myers and Stauffer has developed a model that compares Kansas physician fees to three different benchmarks: an average of the Medicaid rates in Missouri, Iowa, Indiana, and Nebraska; Medicare fees in Kansas; and a limited sample of private insurance fees in Kansas.

LETTER TO: Ann Koci
FROM: James M. Verdier
DATE: January 8, 1998
PAGE: 2

Kansas Medicaid physician fees could be set at 84 percent of the four-state Medicaid average at no increase in cost above the current physician reimbursement expenditure level of $62 million a year -- a "budget neutral" change. For an additional cost of $11 million a year, the Kansas fees could be set at 100 percent of the four-state Medicaid average. Setting Kansas Medicaid fees at 100 percent of Kansas Medicare physician fees would add about $40 million a year to current Medicaid physician expenditures. Setting Medicaid fees equal to private insurance fees could cost up to $70 million a year above the current level.

Modifying Medicaid physician fees to bring them more in line with those paid by other state Medicaid programs, Medicare, and private insurers could be a useful first step toward adoption of the Resource-Based Relative Value System (RBRVS) for physician reimbursement that is used by Medicare as well as about half of state Medicaid programs and an increasing number of private insurers.[1] Even without going to a full-scale RBRVS system, a fee schedule that matched the four-state Medicaid average would significantly increase the incentives for physicians to provide primary care services. In addition, because hospital outpatient reimbursement in Kansas is tied to the physician fee schedule, a revised physician fee schedule would increase outpatient reimbursement -- a goal you mentioned in our initial meetings.

BACKGROUND

The Center for Health Care Strategies (CHCS) conducted a managed care "Readiness Assessment" in Kansas in February 1997. In the course of that assessment, you expressed the concern that the capitated rates Kansas has set in its HMO managed care program (PrimeCare Kansas) may not be adequate to assure access to care by Medicaid recipients. You indicated the need to compare the Kansas Medicaid rates to those of other payers. Many Medicaid physician reimbursement rates, for example, had not been changed since the 1970s, and providers complained that they were well below market rates. Since federal regulations require that the costs of Medicaid managed care programs not exceed the costs of fee-for-service Medicaid, states have only a limited ability to increase capitated rates without at the same time increasing fee-for-service rates. You also expressed the concern that low Medicaid fee-for-service physician reimbursement rates could threaten access in Kansas' planned children's health insurance expansion, to the extent it relies on the Medicaid program.

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[1] The RBRVS payment methodology was phased on for Medicare from 1992-96. It raised reimbursement levels for primary care services and lowered reimbursement levels for certain specialty services.

LETTER TO: Ann Koci
FROM: James M. Verdier
DATE: January 8, 1998
PAGE: 3

Based on its readiness assessment, CHCS agreed to provide Kansas Medicaid with technical assistance in further assessing the relationship between its fee-for-service physician reimbursement system and its HMO capitated rates, and in making appropriate recommendations regarding the physician reimbursement system. I visited Kansas on October 22-23 for discussions with you, your staff, the Kansas Medical Society, and several HMOs. Since then, with extensive assistance from Myers and Stauffer and your staff, I have prepared the analysis and options that are set out in this memo.

PHYSICIAN REIMBURSEMENT REFORM OPTIONS

Myers and Stauffer has constructed a model of the Kansas Medicaid physician reimbursement system that permits your staff to experiment with a wide range of modifications to the current physician fee schedule. The model will calculate the net fiscal impact of changes in any one or more of 600 procedure codes. The model permits easy comparisons on a code-by-code basis to three main benchmarks:

- The average rate paid by Missouri, Iowa, Nebraska, and Indiana ("four-state Medicaid average")
- The Kansas Medicare fee schedule
- The rates paid by two large Kansas private insurers (one HMO and one Preferred Provider Organization (PPO))

As a starting point, I would recommend using the four-state Medicaid average. The states are similar to Kansas both geographically and demographically, and their rates are reasonably close to the national average for state Medicaid programs. The other benchmarks can be used for purposes of comparison, especially if Kansas decides to depart from the four-state Medicaid average for particular procedure codes.

The remainder of this section highlights some comparisons of the fiscal impact of the three main benchmarks, and describes in more detail the impact by type of procedure that would result from moving from the current Kansas Medicaid fee schedule to the four-state Medicaid benchmark.

As shown in the table on the next page, setting Kansas Medicaid physician fees at 84 percent of the four-state Medicaid average would be a "budget neutral" change. There would be no net increase

in expenditures. Setting fees at 100 percent of the four-state average would cost about $11 million per year more than the current system.[2]

Fiscal Impact Of Potential Modifications To Kansas Medicaid Physician Fee Schedule ($ in Millions)

	Annual Expenditures	$ Increase	Percent Increase
Current fee schedule	62	0	0
84% of 4-state Medicaid avg.	62	0	0
100% of 4-state Medicaid avg.	73	11	18
100% of KS Medicare	102	40	65
100% of private PPO/HMO	120-130	60-70	100-110

SOURCE: Myers and Stauffer

As shown in the table on the next page, setting Kansas physician fees at 100 percent of the four-state Medicaid average would result in increases for most types of procedures. The rates for some radiology and surgery procedures would be reduced, while others would be increased. The biggest overall dollar reductions would come in maternity procedures, where Kansas in recent years has substantially increased physician reimbursement. For all maternity procedures combined, the reduction would be about 15 percent.

[2] Because the Myers and Stauffer model on which these fiscal estimates are based does not include all physician reimbursement procedure codes, the actual fiscal impact of the changes could be about 10 percent above or below the estimates derived from the model.

LETTER TO: Ann Koci
FROM: James M. Verdier
DATE: January 8, 1998
PAGE: 5

Selected Major Changes In Expenditures From Setting Kansas Physician Reimbursement Fees At 100% Of Four-State Medicaid Average, By Type Of Procedure

Code Range	Type Of Procedure	$ Change (In Millions)	% Change
99217-99238	Hospital care	3.0	114
99201-99215	Office visits	2.7	27
99280-99285	Emergency room visits	1.6	147
90700-90745	Immunization	0.5	174
99250-99255	Inpatient consultations	0.4	77
99240-99245	Outpatient consultations	0.4	76
70010-79999	Radiology	-0.1	-2
33010-37799	Cardiovascular surgery	-0.1	-8
59000-59899	Maternity	-2.0	-15

SOURCE: Myers and Stauffer

More Selective Modifications To The Physician Fee Schedule

Once the state decides on the overall dollar amount that is available to fund modifications to the physician fee schedule, it would be useful to consider more selective changes to the fee schedule, rather than setting all rates at some percentage of a benchmark such as the four-state Medicaid average. The Myers and Stauffer model is set up so that the fiscal impact of any combination of changes can be quickly calculated.

If, for example, the state is reluctant to make major reductions in reimbursement for maternity procedures, some of the increases in other procedures that would result from using 100 percent of the four-state Medicaid benchmark could be scaled back. Representatives of the Kansas Medical Society and the HMOs with whom the Medicaid program has contracted could likely provide valuable advice on potential trade-offs of this sort. In addition, because many of the increases from setting rates at 100 percent of the four-state Medicaid average would go to hospital based physicians and to outpatient hospital reimbursement, hospital representatives should probably also be involved in the discussions.

LETTER TO: Ann Koci
FROM: James M. Verdier
DATE: January 8, 1998
PAGE: 6

Longer-Term Physician Reimbursement Reform Options

The RBRVS physician reimbursement system that Medicare is now using throughout the country is also used by about half of state Medicaid programs and a steadily increasing number of private insurers.[3] The RBRVS system is scientifically based and carefully constructed. It is continually being refined and improved by the Health Care Financing Administration. The system is designed so that states can adjust the so-called "conversion factor" in the system to achieve whatever fiscal impact they wish, without modifying the rest of the system's structural features.

One of the main purposes of the RBRVS system is to shift reimbursement resources from surgical to primary care services, or from "procedural" to "cognitive" physicians. Moving the current Kansas reimbursement fee schedule in the direction of the four-state Medicaid average would have a similar effect, although it would be less thorough and more systematic than the RBRVS system. It could therefore set the stage for a move to an RBRVS system at a future point. Developing an RBRVS system requires the investment of significant time and analytic resources, but there are models available in other state Medicaid programs that can provide good starting points. Myers and Stauffer is familiar with a number of these models, including the one now being used in the Indiana Medicaid program.

Problems With Using Currently Available Private Insurance Data As A Benchmark

As we discussed, Myers and Stauffer has received private physician fee schedule data from the Department of Health and Environment covering two HMOs and two PPOs. The data from one of the HMOs and one of the PPOs are very incomplete; only about 10-20 percent of the procedure codes overlap with the 600 physician procedure codes in the Myers and Stauffer model. There is about a 90 percent overlap in the data from the other PPO, and about a 65-70 percent overlap in the data from the other HMO. Even with these latter two fee schedules, however, there are many inconsistencies between the procedure codes in those schedules and the Medicaid codes, since insurers are not required in their commercial business to abide by the HCFA requirements for procedure code uniformity and consistency that apply to Medicaid and Medicare claims.

Nonetheless, it will be useful to have this private insurance benchmark as you look at specific procedure codes that may be especially sensitive because of their clinical or fiscal impact, such as the maternity codes. The private insurance rates have been loaded into the Myers and Stauffer model, so they are readily available for comparison to the Kansas Medicaid fee schedule.

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[3] Martin, Sean. "Increasingly, payers use Medicare's physician pay scale." *American Medical News*, December 1, 1997.

LETTER TO: Ann Koci
FROM: James M. Verdier
DATE: January 8, 1998
PAGE: 7

RELATED ISSUES

There are two related issues that are worth reiterating here: phase-in options and measurement of physician participation and recipient access.

Phase-In Options

There are some possibilities for phasing in or front-loading increases in physician reimbursement rates if budget or other circumstances warrant it. If there are funds available for increases in FY 1999, for example, but some uneasiness about the availability of funding in later years, a phase-in that limited the increase in expenditures in later years could be used. Some key physician rates could be increased in FY 1999, but offsetting reductions elsewhere in the physician fee schedule could be postponed until FY 2000 and beyond. Alternatively, savings could be sought in other parts of the Medicaid budget to offset the costs of physician fee increases in later years. In addition, it is worth noting that if there are no further increases in physician reimbursement rates in later years, their real value will be eroded by inflation over time.

Measurement Of Physician Participation And Recipient Access

Finally, you should be sure to track physician participation and recipient access to see whether the increases in physician reimbursement have the desired impacts on access to care:

- **Physician participation.** Your claims processing system should be able to track the number of physicians who submit a specified number of claims during the course of a year, so that you can see whether that number goes up following an increase in physician reimbursement. It would be especially helpful to track this by physician specialty, since the fee schedule increase options described above are likely to have their greatest impact on primary care physicians and those involved in providing maternity care. If there is concern about the potential impact of reductions in maternity care fees on access, for example, tracking and monitoring efforts could focus in particular on physicians who specialize in maternity care.

- **Recipient access.** Recipient access is a more direct measure of the results you would presumably like to achieve with physician fee increases. Your claims processing system should be able to track measures such as the percentage of Medicaid-enrolled children receiving any physician services, the number of physician office visits per enrolled child, and the number of physician office visits per enrolled pregnant woman. It would also be useful to track emergency room visits, since improved primary care usually reduces such visits. If emergency room fees are substantially increased,

LETTER TO: Ann Koci
FROM: James M. Verdier
DATE: January 8, 1998
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however -- as they would be under most of the options discussed earlier -- that could result in an offsetting increase in emergency room utilization.

. . . . . .

I hope this is helpful. Please let me know if you have any questions, or would like me to develop any of this further.

Sincerely,

James M. Verdier

cc: Karen Brodsky, Stephen Somers, Scott Simerly

Kansas Department of Social and Rehabilitation Services
Adult and Medical Services Commission
State Children's Health Insurance Program *(Federal Title XXI)*
Kansas Insurance Coverage for Kids *(KICK)* Proposal
January 15, 1998

Issue Statement:

Kansas has the opportunity to offer health care coverage to 60,000 uninsured children by matching federal monies with a state match of funds.

The Social Security Act was amended in August 1997 to add Title XXI which established federal funds for states to have a State Children's Health Insurance Program. Currently, most uninsured children come from low-income families. According to the Federal Register, September 12, 1997, Kansas has 60,000 uninsured children. These children are in families that generally make too much money to qualify for existing Medicaid health care coverage. The parents are employed in jobs that may not offer affordable health insurance. For these individuals, affordability remains a major obstacle to obtaining health care coverage.

Background for KICK:

On September 23, 1997, the Department of Social and Rehabilitation Services under the direction of Secretary Chronister began addressing the issue of how to reach the uninsured children in Kansas with a day long workshop which incorporated community, advocacy, and insurance leaders. This workgroup became known as KICK, Kansas Insurance Coverage for Kids. The subsequent meetings were chaired by Senator Sandy Praeger, Lawrence. More than 30 individuals who represented the Kansas legislature, advocacy groups, insurance agencies and businesses formed the KICK executive task force.

KICK Goals:

- Reach all children under 200% of federal poverty level (FPL) with quality health care to improve the health status of children in Kansas. This means a focus on education and outreach programs, utilizing existing community organizations, schools, etc.;
- Create a program that is sustainable with the expansion funding from the federal government (Title XXI);
- Be innovative;
- Reduce the complexities of the current Medicaid program;
- Provide equalization of benefits for the existing Medicaid beneficiary.

KICK Recommendations:

- KAN Be Healthy (EPSDT) benefit package (includes mental health and dental)
- Managed Care models for service delivery (capitation where available)
- Cost sharing for families above 150% FPL within the limitations provided by the law
- Seamless program which combines Title XIX and Title XXI eligibility
- Utilize Medicaid managed care quality assurance guidelines

Eligibility Process:

- Simplified application form for Title XIX and Title XXI
- Availability of workers during non-traditional business hours and sites
- Eligibility will be determined in a centralized location
- Twelve months of guaranteed eligibility to insure continuity of medical care
- Equalization of Medicaid allows for the same benefits for all children

Funding and Reimbursement:

- Kansas federal allotment will be $30,809,906 (71.8%) with a state fund match of $12,100,827 (28.2%).
  Source: Health Care Financing Administration, December 1997
- Administration and marketing are allowed to be 10% of total expenditures--not total allotment

Implementation Planning:

Nine workgroups are addressing the detail of implementation plans. These groups began working in November, 1997 and include state staff, advocacy and provider representatives.

- Benefit Package	- Financial Eligibility	- Systems
- Quality Assurance	- State Plan/Regs	- Finance
- Marketing/Outreach	- Training	- Rates

Outreach/Marketing:

- Private contractor develops name and logo for program
- Family friendly design that eliminates welfare stigma
- Use existing community based locations for access to the program; ie: schools, health departments., hospitals, physician offices etc.
- Mixed media including Public Service Announcements will be used to provide information
- Toll-free phone line will be used for information and access

Marketing of this program will begin in August 1998 to coincide with school enrollment. The delivery of health care services will begin on January 1, 1999.

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PROVIDING CHILDREN'S HEALTH INSURANCE COVERAGE IN KANSAS

A Report To The Kansas Legislative
Health Care Reform Oversight Committee

December 3, 1997

Kansas Insurance For Kids SRS Workgroup
Senator Sandy Praeger, Chair

Children's Health Insurance Action Group
Insurance Commissioner Kathleen Sebelius, Chair

Introduction

Children are our most valuable resource. How we treat children is a true measure of our society. It is important that we provide them with all of the necessary tools to prepare for their future.

For many Kansas families, access to health care remains out of reach. This is true despite the fact that most of those who can not afford health insurance are employed. This report outlines the scope of the problem in Kansas and provides a series of steps which can be taken to provide health insurance for the approximately 60,000 children of working poor families who do not have coverage.

According to a recent study by the U.S. Census Bureau, there are 73,000 children in Kansas under 18 years old, or 10.4 percent of all children in the state, without health insurance. These are children who are not eligible for public health assistance programs such as Medicaid. This compares with 13.8% of all children nationally (almost 9.8 million) who do not have health insurance coverage. The Kansas Department of Social and Rehabilitation Services estimates that there are 60,000 children in the state whose families do not work in the public sector and who earn less than 200% of the federal poverty level ("FPL") who do not qualify for Medicaid. These government statistics are supported by a recent survey by the University of Kansas which found that 9.4% of children in Kansas under 18 (64,215 children) currently do not have health coverage.

Many uninsured children are in families who are employed in jobs which either do not provide health insurance or where the premiums are not affordable. The Health Affairs Journal reports that between 1987 and 1996, the national percentage of workers with health insurance coverage through their employer dropped from 64% to 60%. The decline in health insurance coverage is most apparent for working poor families and for black and Hispanic workers.

There is a clear link between health insurance and access to health care. A 1994 National Health Interview Survey found that long term uninsured children receive fewer doctor visits and less in-patient hospital days. Uninsured children also have problems receiving necessary dental care, prescription drugs or eyeglasses. These are services that are critical for childhood development, especially in 0-5 years of age.

Federal Children's Health Insurance Legislation

This year, the Congress has provided state governments, including Kansas, with a unique opportunity to address the problem of children who do not have access to health insurance. In August, Congress approved funding for a state children's health insurance program as part of the 1997 Budget Reconciliation Act. The new law provides $48 billion in federal funds over 10 years for children's health coverage. Major provisions of the act include:
The Federal government will invest $24 billion over the next five years and there is the

possibility of an additional $24 billion over the following five years. Funds will go to children's health insurance, increased Medicaid costs and diabetes programs. The program is partially funded by increased tobacco taxes.

In Kansas, the program can provide coverage for qualified children in families with incomes at or below 200% of the federal poverty level.

Kansas is estimated to receive $31,433,507 in the first year and a five year total of over $152 million. Funding starts October 1, 1997. Any money not allocated by a state in a particular year may be used during the two following years. At the end of three years, any unallocated funds are redistributed to the other states.

States must provide matching funds equal to 70% of the amount of the state contribution to Medicaid. Kansas share for the first year (assuming all federal funding will be used) is $12.3 million.

The money may be used by states to (a) expand Medicaid and (b) provide comprehensive private health insurance through a state children's health insurance program. Funds can not be used to duplicate any other private or public coverage that is available. Up to 10% of the funds can be used for administrative and outreach costs and for funding other health assistance programs for children.

Benefits under the private health insurance program must provide "benchmark coverage" of basic services. This coverage is equivalent to that provided by: (a) the standard Blue Cross plan for federal employees; (b) the largest commercial health maintenance organization with the largest insured, non-Medicaid enrollment or (c) health benefits offered to state employees.

States are required to submit a plan of how the funds will be used to the Secretary of Health and Human Services for approval. State plans must include details of "outreach" efforts to expand coverage to targeted population.

Families with incomes above 150% of the FPL can be asked to pay a portion of the premiums. Certain deductibles and co-pays are also permitted.

States must adopt procedures to ensure that coverage under this program does not "crowd-out" or substitute for existing employer coverage.

Eligibility for assistance may not be denied based on preexisting conditions. Group health plans may limit coverage of services for preexisting conditions.

One of the most important things for the 1998 Legislature to do is to take advantage of this program to provide assistance to those children whose families can not afford private health insurance, but who also do not qualify for Medicaid assistance from the state. The benefits of assisting Kansas working parents to provide health insurance coverage for their children include

reduced medical costs and a healthier future for the citizens of Kansas.

Kansas Children's Health Insurance Proposal

There are two groups which have been looking at developing a program to provide health insurance coverage for children in this state based on the provisions of the Budget Reconciliation Act. In July, Insurance Commissioner Kathleen Sebelius formed the Children's Health Insurance Action Group to study ways to fund health insurance coverage for uninsured children in the state. This group includes many representatives from the Commissioner's Health Care Advisory Committee which has studies a number of health issues over the past three years.

In September, the Secretary of the Department of Social and Rehabilitation Services, Rochelle Chronister, established a committee to develop a plan to use the funding made available through the federal legislation. This Chair of this committee is Senator Sandy Praeger. The SRS group has looked at the issue as a way to redefine and change the identity of the existing Medicaid program while the Insurance Department's Action Group has focused on ways in which the private market can participate in providing health coverage for uninsured children.

Both groups include representation from a wide range of groups interested in children's issues such as advocacy groups, public health clinics, medical providers, legislators and insurance carriers. In many cases, members of the Children's Health Insurance Action Group were also represented on the Kansas Insurance Coverage for Kids ("KICK") Workgroup. A list of the membership of the two committees is attached to this report as Attachment A. Minutes of the meetings of the groups and other meeting materials are included as Attachments B and C.

It is important to note that the two committees worked toward a common goal of designing a children's health program for Kansas that would maximize the resources available to the state. The Action Group and the KICK Workgroup were also committed to providing a plan that would utilize a public-private partnership to deliver services to children. Both groups came up with the same general outline of a children's health program for Kansas.

The operating principals developed by the Children's Health Insurance Action Group and the Kansas Insurance Coverage for Kids SRS Workgroup are as follows:

The target population is the approximately 60,000 uninsured children in Kansas whose family incomes fall below 200% of the federal poverty level. The program should be designed to provide comprehensive health coverage for as many children as possible.

The program should be sustainable with the expansion funding from the federal government (Title XXI).

The program should be innovative and utilize the private market to provide coverage for uninsured children.

The program should maximize the purchasing power of the state by pooling the eligible children with other groups which are provided insurance through the state such as the existing

Medicaid program.

The new insurance program for Kansas children should be designed to coordinate and compliment existing health services for Kansas children.

The program will put the focus on the prevention of disease and illness in children and provide better health outcomes for children, reduce costs and reduce the documentation and paperwork for health care providers. A focus on wellness and prevention results in healthier children who have greater success in school.

The program should equalize Medicaid benefits for all Kansas children at 150% of the federal poverty level. Currently, Medicaid covers 0-1 year olds up to 150% of FPL; 1-6 year olds at 133% of FPL and 7-18 year olds at 100% of FPL. This equalization will allow households under 150% of the federal poverty level to have access to Medicaid regardless of the age of the children and will reduce the complexities of the current Medicaid program.

The state will competitively bid a benefit package identical to Medicaid in the private insurance market to enlist insurance carriers to provide children's health insurance for families between 150% and 200% of the federal poverty level. This will allow the state to purchase health care for eligible children in the same way an employer purchases health care for their employees. The purchase of coverage will be done through a request for proposal issued by the state.

One goal of the program is to remove the stigma of health care provided through Medicaid and assist the transition from welfare to full employment.

The package of benefits to be offered will be the same for all children under the 200% FPL. This will allow for seamless coverage for families as they change income levels and will allow children to have access to the same set of benefits and providers as they change programs. As Kansas families move from welfare to work, health insurance for their children will be consistent.

Insurance companies will be required to form partnerships with local community health systems including providers and community health departments for the delivery of services.

The contract should include incentives for insurers to provide outreach efforts to meet specific outcome measures for the delivery of health services.

Parents with incomes above 150% of the federal poverty level should share in the cost of the program through a sliding scale of premiums, provided that such efforts do not discourage access to health coverage.

The program will use day care centers, public schools, hospitals, medical providers, health clinics and other community organizations for outreach efforts to enroll eligible Kansas children with a simplified enrollment form.

The state may want to provide premium tax incentives for those insurance carriers which participate in the program.

The two working groups have a joint meeting scheduled for December 18 to continue to explore implementation issues. As with any proposal, there are a number of program details that remain to be worked out. Those issues include:

Decide on the most appropriate administrative structure to oversee the private contracts. Options include the Department of Social and Rehabilitation Services, the State Employees Health Care Commission, or a new administrative agency.

Reduce the potential "crowd-out" of existing employer based health insurance. The KICK group has proposed that there be a six month waiting period after someone loses private insurance before they qualify for the children's health insurance program.

The design of the contract proposal for private health insurance coverage needs to be finalized. One issue is whether the state outlines in the proposal a list of benefits and asks carriers to bid a premium amount or, as an alternative, sets out a per child amount and requires insurance companies to indicate what benefits can be provided for that level of funding.

The Caring Program For Children is a public-private partnership established by Blue Cross and Blue Shield of Kansas, the Kansas Hospital Association and the Kansas Medical Society and partially funded through state dollars. This program provides basic health care services for many children who are in the targeted population. The future of the Caring Program For Children needs to be decided and ideally can be focused on those uninsured children outside the target population..

In addition, the program should be evaluated as a possible way to provide health insurance coverage for children in families above the 200% of FPL cut-off. These families would be required to pay full premiums for such insurance.

Outreach efforts need to be further clarified and the application process needs to be designed so that it provides streamlined and efficient access to the program.

The state should look at the current system for Medical Support Orders in domestic cases to see if access to the Title XXI program should be required in appropriate cases.

The Legislature should use state dollars to provide comprehensive insurance for children of public employees in the targeted income level.

This Legislature has the opportunity to provide health insurance coverage for over 60,000 Kansas children who currently do not have access to regular health care. It is the best investment we could make in the future of Kansas.