Approved: March 12, 2002
Date

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Garry Boston at 2:00 p.m. on February 25, 2002 in Room 210 Memorial Hall

All members were present except: Representative Sue Storm, Excused

Committee staff present: Dr. Bill Wolff, Kansas Legislative Research Department
Norman Furse, Revisor of Statute's Office
Renea Jefferies, Revisor of Statute's Office
June Evans, Secretary

Conferees appearing before the committee: Kevin Robertson, Kansas Dental Association
Laura Howard, Health Care Policy, SRS
Connie L. Hubbell, Secretary, Department on Aging
David Lake, Director, Board of Emergency Medical Services
Bob Orth, President, Kansas Emergency Medical Technicians Association
Jason White, Vice President, KEMSA
Chris Collins, Director of Government Affairs, Kansas Medical Society

Others attending: See Attached Sheet

The Chairman apologized for starting the meeting late due to the House being in Session. There was no sub-committee meeting therefore, there will not be a report on **HB 2912.** If we get that far we will still have a hearing on **HB 2912.**

Kevin J. Robertson, CAE , Executive Director, Kansas Dental Association, gave an update on dental access for all Kansans. Kansas is in need of additional Dental Medicaid/Healthwave providers. Currently 400 dentists are enrolled in the Medicaid program with about 280 actively providing care. There are 1200 actively practicing dentist in Kansas, of these, approximately 220 are specialist. This leaves a pool of less than 1,000 general dentists to provide basic preventive and restorative care to all Kansas citizens and from which to draw providers to provide Medicaid/Healthwave services.

The KDA is working to divert this pending dentist shortage by advocating legislation to create more seats for Kansas students at dental schools, and a dental scholarship program that would require the recipients to work in rural areas of Kansas (Attachments 1 & 2).

Laura Howard, Health Care Policy, Kansas Department of Social and Rehabilitation Services, responded to request for information regarding health care services provided by SRS, and the associated costs of these services. More than 200,000 Kansans will access services for acute health care needs through the Medicaid program and the State Children's Health Insurance program this year. SRS also plays a key role in the provision of long-term care services for persons with disabilities, primarily through our home and community based services waiver programs (Attachment 3).

Due to time constraints, the Chairman asked Ms. Howard to come back at a later date to complete the update and encouraged the members to read the report.

Secretary Connie L. Hubbell, Department on Aging, responded to request for information regarding health care services provided by KDOA and the cost/benefits of those services. KDOA is the primary purchaser, using public funds, of long term care services for the elderly. Health care programs provided by the Kansas Department on Aging are long term care services

that support Kansas seniors in maintaining optimum levels of health at the lowest public cost (Attachment 4).

The Chairperson opened the hearing on **HB 2912 - Emergency Medical services - professional levels, activities, licensure.**

David Lake, Director, State Board of Emergency Medical Services, testified as a proponent to **HB 2912**, stating the first issue is one of adding the term and definition for a "paramedic" to K.S.A. 65-6112 and the second issue is allowing the Board of EMS to identify authorized activities for an EMT, EMT-Intermediate, and EMT Defibrillator through rules and regulations (Attachment 5).

Bob Orth, President of the Kansas Emergency Medical Technicians Association, a proponent, stated what EMT's are allowed to do is set by statute. EMT's can not deliver or even carry an aspirin, use a pulse oximeter which is a device that measures the saturation level of oxygen by sensing the color of blood as it circulates through the body, or prick a finger and reading the drop of blood with a glucometer. Ambulance services would better serve its constituency if allowed to provide these services (Attachment 6).

Jason White, KEMSA, a proponent, stated the debate around the bill centers on the issue of "authorized acts." The provision of emergency health services via the technicians with ambulance services is regulated at several levels that are much more successful that the current reliance on the legislative process (Attachment 7).

Chris Collins, Director of Government Affairs, Kansas Medical Society, testified as an opponent to **HB 2912**, stating the Kansas Medical Society has historically supported the activities of the EMS Board and understands and appreciates the critical role that emergency medical service providers play in the delivery of emergency health care. KMS remains supportive of the EMS Board's goal to update its act. Nonetheless, passage of **HB 2912** would represent a material deviation from the law governing almost all other health care professionals. This bill would permit the Board of EMS to determine its own scope of practice by rule and regulation (Attachment 8).

Terri Roberts, J.D., R.N., provided written testimony in opposition of **HB 2912** (Attachment 9).

The meeting adjourned at 3:25 p. m. and the next meeting will be February 26.

HEALTH AND HUMAN SERVICES

DATE February 25, 2002

NAME	REPRESENTING
Kevin Robertson	Kansas Dental Assn
David Lake	KBEMS
Robert Roth	EMS
Jason White	EMS
Jon Josserand	
Laura Howard	SRS
MARY FEIGHNY	KBEMS

KANSAS DENTAL ASSOCIATION

Date: February 25, 2002

To: House Committee on Health and Human Services

From: Kevin J. Robertson, CAE
Executive Director

Re: Dental Access

Chairman Boston and members of the Committee I am Kevin Robertson, executive director of the Kansas Dental Association (KDA) which represents about 80% of Kansas' practicing dentists. I am here today to discuss dental access. Dental access for all Kansans is an issue of concern in Kansas which the KDA shares. The KDA has been a participant in most every meeting, conference, workshop, study group, and discussion session on the issue over the past four years and, in fact, co-hosted the Kansas Oral Health Summit with the Kansas Public Health Association in December, which explored access issues. There is no shortage of good ideas to improve oral health access. Solutions include increasing the number of dentists and dental hygienists by creating a new dental schools, increasing the number or dental school seats for Kansas residents, mobile vans, raising Medicaid reimbursement, creating a new state Office of Dental Health, creating a dental scholarship program, working to gain matching funds for dental operatories in nursing homes, and on and on and on Let me take a moment to share some of the KDA's activities in the area of dental access over the past year.

Kansas Medicaid/HealthWave – The KDA continues to work and meet with the Kansas Medicaid administrators regularly in an effort to better the program. The June 2001 changes in administration from Delta Dental and Bridgeport to Doral Dental were met with criticism and mixed reviews from the dental community. Nevertheless, the KDA is working closely with Doral and the Division of Medicaid to make Kansas Medicaid as user friendly as possible. Over the past year the bureaucracy has become less onerous, reimbursement is higher, and the administrator seems to be more helpful. Improvements have been slow, but I'm please to report they are being made.

Kansas is in need of additional Dental Medicaid/Healthwave providers. Currently 400 dentists are enrolled in the Medicaid program with about 280 actively providing care. There are 1,200 actively practicing dentist in Kansas, of these, approximately 220 are specialist. This leaves a pool of less than 1,000 general dentists to provide basic preventive and restorative care to all Kansas citizens and from which to draw providers to provide Medicaid/Healthwave services. In addition, several dentists limit their practices to adults or children over a certain age. As was discussed by Joyce Cussimanio on Thursday, the KDA and others are partnering to provide a pilot ABCD program in three Kansas communities. One of the components is to provide training to dentists and staff on caring for children to ease their fears of providing dental services to children. By doing so, we hope to increase the number of Medicaid/Healthwave providers.

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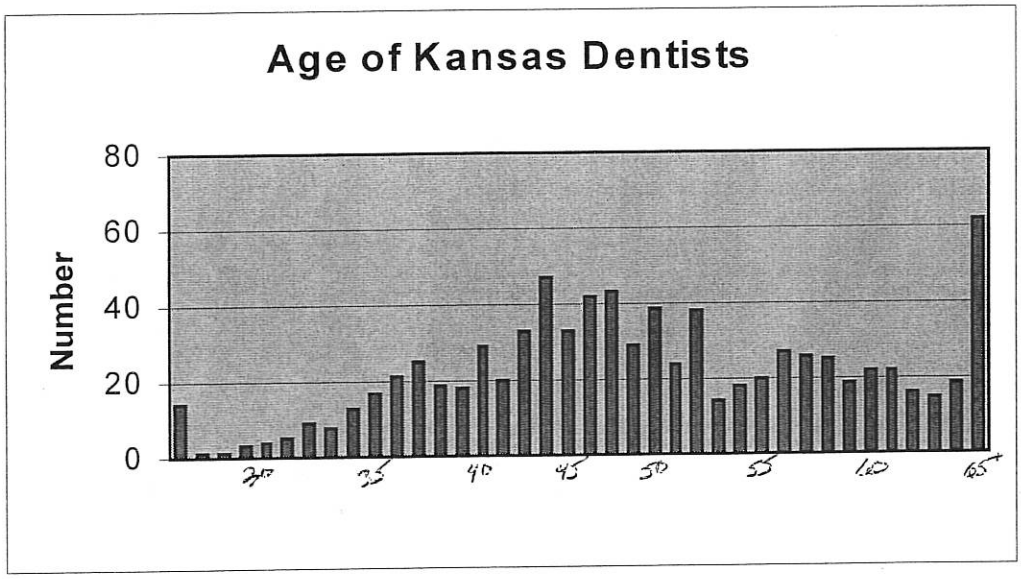
H s HHS
2-25-02
Atch #1

Fluoridation/Sealants –The United Methodist Health Ministry Fund (UMHMF) has carried the banner for a three-prong dental access initiative that began in 1998. The KDA, as a participant on the dental advisory committee for the UMHMF along with several KDA member dentists, has played an important and ongoing roll setting up dentist networks to provide sealants as a preventive procedure in targeted lower income areas. Many local dental societies and individual dentists have offered their time and efforts to see that children's teeth are sealed. In addition, the KDA works with local communities to encourage them to fluoridate their city water. Though fluoridation has been widely accepted in the U.S. since 1947, Kansas still falls below the national average of percent of population fluoridated with only 62%. This is largely due to the fact that Wichita is the nations 3rd largest non-fluoridated community.

Dentist Shortage – Kansas does not have a dental school. Kansas relies on an agreement with the State of Missouri to provides approximately 55 dental seats for Kansas students at the UMKC School of Dentistry. In return, about 490 seats are made available to Missouri students for architecture and engineering school at KU and K-State. At the rate of 11-13 Kansas students graduating from UMKC each year, Kansas will soon (if not already) face a shortage of dentists. Additionally, many of the Kansas students graduating from UMKC do not return to Kansas – certainly not rural Kansas. A brief review of the age data of Kansas dentists shows that the number of incoming dentists in Kansas is not keeping pace with those reaching retirement age. The data below (1999) of the ages of Kansas dentists illustrates this concern.



The KDA is working to divert this pending dentist shortage by advocating legislation to create more seats for Kansas students at dental schools, and a dental scholarship program that would require the recipients to work in rural areas of Kansas. By working on solutions now, the KDA hopes to eliminate a potential crisis for dental services in the future. UMKC has announced an increase in its class size beginning in the Fall of 2002. Unfortunately, two bills critical to increasing the number of dentists in Kansas stalled in the House Committee on Higher Education after they passed the Senate without a single no vote. I urge the Committee to support SB 213 and SB 333. In the KDA's opinion, the critical component to increasing dental access for all Kansans – public assistance, third party reimbursement, or private pay – hinges on increasing the number of dentists in the state.

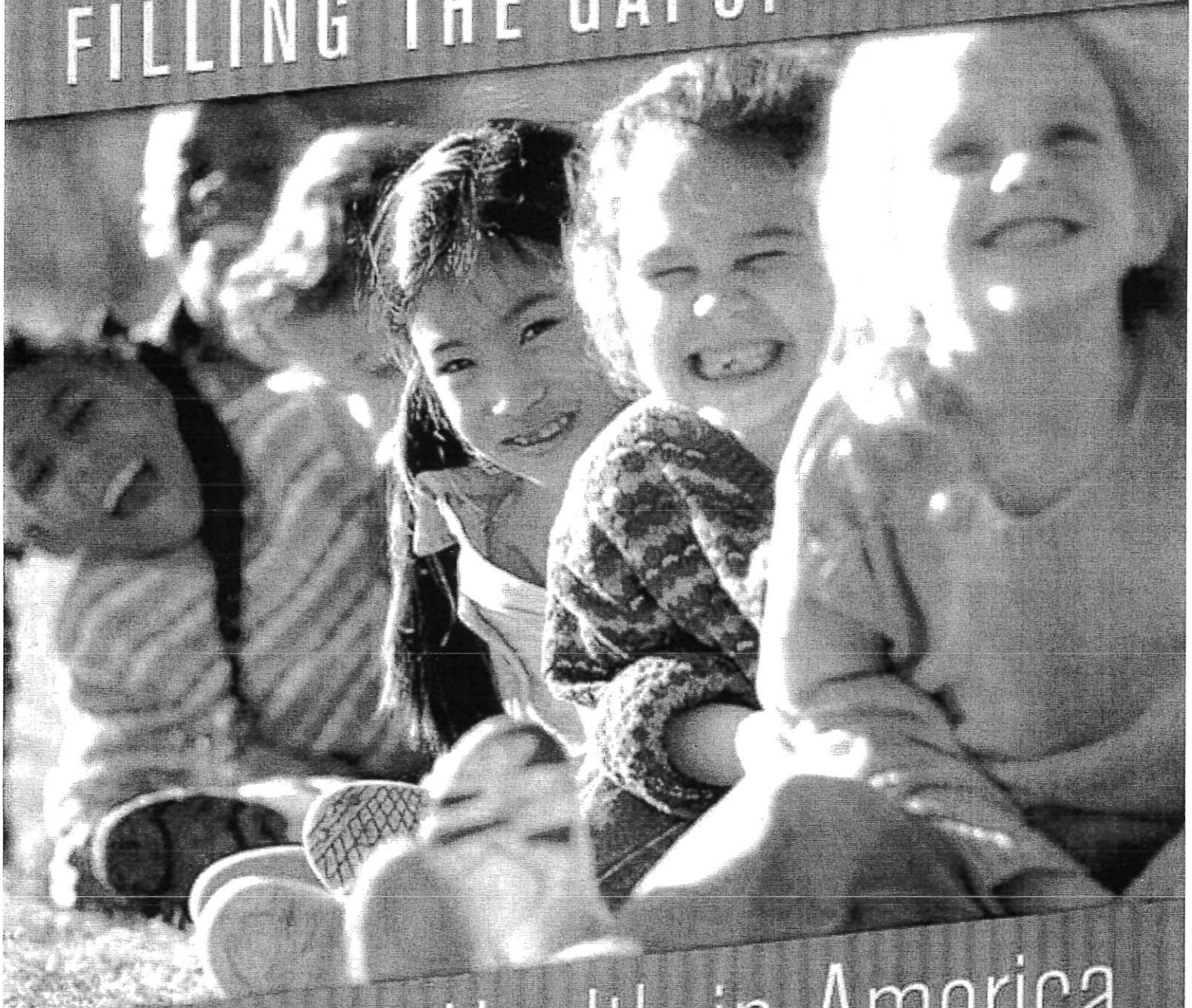
Dental Hygienist Shortage – The KDA continues to seek additional opportunities for dental hygienist training in Kansas. In 1998, the KDA worked closely with and provided some funding and equipment to help encourage Colby Community College to start its dental hygiene program. Currently, the KDA is working closely with Manhattan Area Technical College in an effort to create a new school of Dental Hygiene by the Fall 2003 semester.

Elderly/Disabled Care – The KDA is a founding member of Promoting Oral Health for Elderly Kansans. Through this organization, the KDA has taken an active roll in working with nursing homes to increase the level of care to the elderly. The KDA also created and supports the Donated Dental Services (DDS) Program administered through the National Foundation of Dentistry for the Handicapped. DDS relies on dentists and dental labs to donate care to low-income elderly and disabled Kansans with dental care needs. Since its inception in November 1996, DDS dentists' have provided $1.6 million in free care to nearly 1,000 persons.

The efforts of the KDA and other organizations, such as the United Methodist Health Ministry Fund, are paying off as the KDA recently improved its Oral Health "grade" from Oral Health America from a "F" to a "C". More can be done, Kansas needs to step to the plate and create a Dental Director position that can coordinate state efforts to promote and increase access in the state. The KDA and Kansas Dental Hygienists Association have agreed to put forth a plan where the two organizations can work on joint projects to increase dental access in Kansas.

Thank you for your time today. I'll be happy to attempt to answer any questions you may have. .

FILLING THE GAPS:



Oral Health in America

THE ORAL HEALTH AMERICA
NATIONAL GRADING PROJECT
2001-2002
NATIONAL GRADE: C

Campaign for Oral Health Parity

Funded in part by The Robert Wood Johnson Foundation

2001 Oral Health Report Card

PREVENTION: C

Fluoridation

Sealants

ACCESS TO CARE: C-

Availability of Dentists

Children's Medicaid Dental Program

Visits to Dentists

Dental Insurance Status of Adults and Elderly

ORAL HEALTH LEADERSHIP: B+

Dental Director

Oral Health Coalition

ORAL HEALTH STATUS: C+

Oral Health of Children

Use of Spit Tobacco

Edentulous Elderly

Oral Cancer Mortality Rates

Comments

ORAL HEALTH OVERVIEW

The nation's grade of a C in oral health for 2001 signifies new possibilities for the future as well as widespread unmet needs. On one hand, there is new energy to improve the nation's oral health. Surgeon General David Satcher's call for attention to the "silent epidemic" of oral diseases in his 2000 report, *Oral Health in America,* is starting to be heard. A number of states have hired dental directors in the past year. This signifies an important step toward supplying vital leadership at the state level. However, much more progress is needed. Too many low-income people lack access to care, and too few communities have taken advantage of cost-effective prevention measures. Many of our children and our older Americans have gone too long without adequate dental care. Improving the nation's oral health grade will require additional leadership and resources. There is much more work to be done.

- Over 108 million U.S. adults and children have no dental insurance.
- For every child without medical insurance, there are 2.6 without dental insurance.
- Poor individuals (66%) are less likely to visit a dentist than the non-poor (46%) in any given year.
- Tooth decay is the most common chronic childhood disease, affecting 50 percent of first graders and 80 percent of 17-year-olds.
- Every year, over 30,000 people develop oral and pharyngeal (throat) cancer.
- Oral/pharyngeal cancer is the 6th most common cancer in U.S. males and the 4th most common cancer in Black men.
- Almost 2.5 million days of work are lost each year due to dental problems.

As the states and the nation as a whole work to improve the health care system, it is important to remember that good oral health is a major contributor to good overall health. Dental disease can threaten a child's health, well-being, and achievement. Children with oral health problems can have difficulty eating and sleeping, and paying attention in school. In addition, researchers are exploring links between adult oral disease and diabetes, heart disease, stroke, and pre-term, low birth weight babies.

ABOUT THIS REPORT CARD

This report card provides a snapshot of oral health in America, using data available at the state level. The grading categories are intended to call greater policy attention to areas of need in prevention, access to care, oral health leadership, and oral health status across the country. They are not intended to grade any one national, state, or local program. The reasons for poor oral health are many, including under-supported prevention measures, lack of insurance, regional shortages of oral health practitioners, and population behavior.

Fortunately, safe and effective oral disease prevention measures do exist, such as community water fluoridation and dental sealants. Many of these measures are cost effective. Individuals, communities, and the health professions must work together to create successful policies and programs that will make oral health care an integral part of overall health care.

PREVENTION: C

Americans cannot underestimate the importance of prevention and preventive services in maintaining a lifetime of good oral health. Tremendous variances exist throughout the states and the District of Columbia when it comes to prevention. Basic, cost-effective preventive measures, such as the fluoridation of public water supplies, have not been implemented in many parts of the country. However, it should be noted that some states are making significant improvements. Even though the state received an F in this category, currently almost 30% of Californians drink fluoridated water, an increase from 17% in two years.

The use of dental sealants remains low, even as a proven means of caries prevention among high-risk children. According to the Centers for Disease Control and Prevention's Synopsis of State and Territorial Dental Programs, three states stand out

in their efforts to reach children through public health sealant programs: Ohio (28,575 children reached in 2001); New York (26,000 children reached in 2001); and Illinois (22,362 children reached in 2001). Other states are working hard to expand their services. Maine, for example, increased its school-based dental sealant program from 38 schools to 91 schools .

Some state dental health programs are leading the way by expanding clinics, developing school-based programs, supporting oral health legislation, and initiating innovative partnerships to improve oral health. For example, North Dakota's state oral health program developed and implemented an oral health component for home health visits to all new mothers to promote good oral health and its impact on overall health throughout life. In other states, community, government, and business leaders are coming together to form oral health coalitions to help address these issues.

ACCESS TO CARE: C-

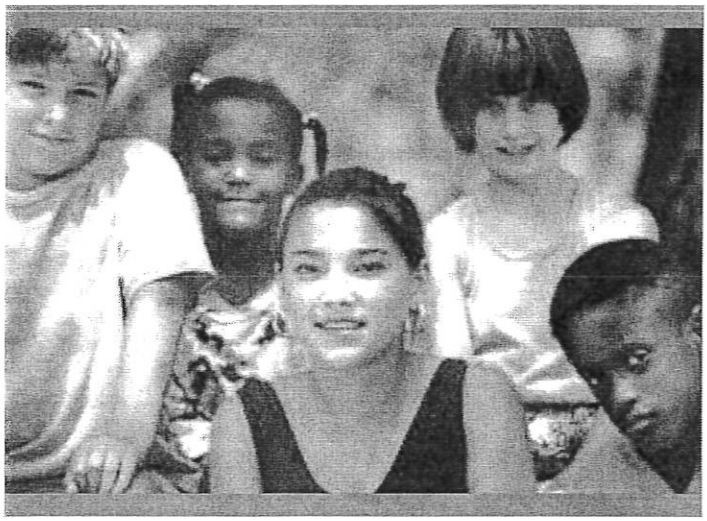
Access to oral health care is a problem for millions of Americans, particularly for children, elderly adults, minorities, and people with disabilities. Many regions of the country have a maldistribution of dentists, and community-based dental clinics, even where they exist, are not sufficient to fill the gap. Private health insurance, designed to

be the cornerstone of the American health care system, is hardly universal and often does not provide dental coverage. The Medicaid dental program and State Children's Health Insurance Program are unable to meet the oral health needs of the more than 108 million Americans who do not have dental insurance. Income plays a major role in who receives services and who does not. If we fail to fill this gap, the U.S. will pay a high and long-term cost for failing to prevent illnesses and treat all of its citizens.

A number of states are leading the way in finding solutions to access problems. In Alabama, the governor increased Medicaid reimbursement rates to 100% of insurance rates, and the state oral health program is educating dental providers and recipients about Medicaid through a grant from The Robert Wood Johnson Foundation. In 2001, Georgia provided $1 million for expanding the Georgia Oral Health Prevention Program statewide to help improve access to dental prevention services for poor children. The Dental Health Division of the Hawaii State Department of Health secured funds to open a comprehensive care dental clinic on the Island of Maui to assure access to care for Medicaid eligible children and adults, including those with disabilities.

ORAL HEALTH LEADERSHIP: B+

The nation has made significant progress in boosting the leadership necessary to improve oral health. Only six states are without a dental director. The formation of dental coalitions in states across the country can be seen as a result of the U.S. Surgeon General's call to action on oral health in 2000. Now that many states have leadership in place to direct and develop innovative programs, it is time to ensure they have the human and financial resources to get the job done.



ORAL HEALTH STATUS: C+

The oral health status of the nation indicates areas of need and oral health conditions, rather than programs and prevention measures designed to address those needs. For example, tooth decay is the single most common childhood disease in the U.S.—five times more common than asthma and seven times more common than hay fever. Poor oral health during childhood can cause health and social problems throughout life. Oral cancer is more common than leukemia, ovarian, thyroid, kidney, pancreatic, and esophageal cancer, and it is rarely diagnosed in the early stages of the disease, thereby leading to higher mortality rates.

Preventive services and access programs developed at the community, regional, and state level can help to reverse these trends. For instance, Maryland is launching an oral cancer mortality prevention initiative including oral cancer screenings and training for dentists, dental hygienists and other health care providers who are the first line of defense in spotting oral cancer.

Increased efforts to track state-specific data will help track progress and provide clearer pictures of areas in need. As we identify policy and educational changes, and develop public-private partnerships to address oral health problems, America must recognize that oral health is a key part of overall health in order to make the grade.

Grading Scale

METHODOLOGY

For the 2001 grading project, Oral Health America gathered public health information available from a variety of sources to develop a state-by-state database. The most recent primary data sources possible were used, including centralized data sources from the Centers for Disease Control and Prevention. In particular, data were collected from the oral health modules of the National Oral Health Surveillance System (www.cdc.gov/nohss) and the Behavioral Risk Factor Surveillance System (www.cdc.gov/nccdphp/brfss/).

Additional state data were obtained from state dental health programs, the American Academy of Pediatrics, Campaign for Tobacco-Free Kids, Health Care Financing Administration/Centers for Medicare and Medicaid Services (CMS), Health Resources and Services Administration (Bureau of Maternal and Child Health), and the National Cancer Institute. Data sources are listed for each grading category.

Grades for each of the categories are based on obtainable data, as well as desired levels of oral health status and use of oral health services. In most categories, grades are based on a national mean or bell curve, by establishing the mean as a "C" grade and assigning other grade ranges based on standard deviations above and below the mean. Some of Oral Health America's grading scales exceed or are more rigid than the Healthy People 2010 standards. For example, given the health risks, Oral Health America could not condone any use of spit tobacco. In this category, "A" equals 0% use.

An "I" represents "incomplete," where there were no data available to provide any measurement of status. In working to improve oral health and oral health care in America, it is particularly important that state-specific measurements of prevention, access, and oral health status are gathered in order to provide baselines for improvement and/or achievement. In several cases, states did not respond to our requests for information, indicated by a "DNR" or "did not respond."

It is our hope that opinion leaders, public advocates, policy makers, and the media will take note of our nation's shortfalls and will work to support existing infrastructure and programs to improve and promote oral health across the country.

REPORT CARD CATEGORIES AND DATA SOURCES, 2001

The following scale was used to assign point values for letter grades in the oral health report card grading:

A	4.00	D+	1.33
B+	3.33	D	1.00
B	3.00	D-	0.67
B-	2.67	F	0.00
C+	2.33	I	Data not available/ no score
C	2.00		
C-	1.67	DNR	Did not respond/no score

PREVENTION

Fluoridation

Grades are based on the percentage of population in each state on public water supplies receiving fluoridated water.

Source: Fluoridation Census 2000, Centers for Disease Control and Prevention, Division of Oral Health.

Fluoridation Grading Scale

Percentage of Population on Public Water Supplies Receiving Fluoridated Water

A	90% - 100%	D	50% - 64%
B	80% - 89%	F	0% - 49%
C	65% - 79%		

Sealants

Dental sealants are among the most cost-effective (and under-utilized) means of protecting children's teeth from tooth decay. Grades are based on the percentage of third-grade children (or 8-year-olds) estimated to have one or more dental sealants on permanent molars. The grading scale is based on the Healthy People 2010 target for increasing the number of children receiving dental sealants on their molar teeth to 50%. This category is difficult to grade because sealant data were derived from different sources for submission to the Maternal and Child Health Block Grant Applications. For example, some states use data derived from dental health clinics, while others use data from needs assessment surveys. The data also do not measure high-risk children specifically. However, despite the flaws in the data, it is too important a category to overlook. For the future, Oral Health America recommends that states adopt a single tool with standardized sampling methodology to gather data on the percentage of high-risk children with one or more sealants on permanent molars.

Source: Health Resources and Services Administration (Bureau of Maternal and Child Health)—Form 11, Title 5 Block Grant Annual Report, 1999.

Sealants Grading Scale

Percentage of Third-graders (or 8-year-olds) with One or More Dental Sealants on Permanent Molars

A	50% - 100%	D	12% - 22%
B	34% - 49%	F	0% - 11%
C	23% - 33%		

ACCESS TO CARE

Availability of Dentists

An adequate supply of dentists is one key to ensuring that the population can access oral health care. Grades are based on the number of professionally active, licensed dentists in each state compared to the state population. Unfortunately, available data do not address the distribution of dentists in rural versus urban/suburban areas, nor do they address the extent to which dentists serve Medicaid or other underserved populations, and the number or type of services they are providing. These factors have a direct impact on access to care, and the availability of such data is critical to determining and prioritizing areas of need.

Source: American Dental Association, Distribution of Dentists in the United States by Region and State: Total No. of

Professionally Active Dentists, 1998; Population information taken from the U.S. Census Bureau web site (www.census.gov) estimate surveys, 2001.

Availability of Dentists Grading Scale

Number of Professionally Active, Licensed Dentists in Each State Compared to the State Population

A	1: 1 - 1,000	D	1: 2,001 - 2,500
B	1: 1,001 - 1,500	F	1: 2,501 +
C	1: 1,501 - 2,000		

Children's Medicaid Dental Program

Historically, publicly funded dental coverage for poor children has not assured their oral health. Medicaid has provided broad dental coverage, but only limited access to care and services, though numbers have improved in the last couple of years. If Medicaid is the way to reach children with oral health services, we need to systematically improve Medicaid services for enrollees.

Grades are based on the percentage of Medicaid enrolled children, ages 0-20, with at least one dental visit in 1999.

Source: Health Care Financing Administration/Centers for Medicare and Medicaid Services (CMS), Lines 1 and 12a of HCFA Form 416 Reports for the Federal fiscal year 1999.

Children's Medicaid Grading Scale

Percentage of Medicaid Enrolled Children, Ages 0-20, With at Least One Dental Visit in 1999

A	50% - 100%	D	5% - 19%
B	35% - 49%	F	0% - 4%
C	20% - 34%		

Visits to Dentists

Although dental visits are vital to maintaining good oral health, many people do not even visit a dentist once a year. Three grades are given for this category:

1. The percentage of all adults, ages 18 and older, with an annual income of less than $15,000, reporting a visit to a dentist or dental clinic;
2. The percentage of all adults, ages 18 and older, with an annual income of $15,000 or more, reporting a visit to a dentist or dental clinic; and
3. The percentage of all adults, ages 18 and older, reporting a visit to a dentist or dental clinic in the past year.

Source: Behavioral Risk Factor Surveillance System (BRFSS), 1999, http://www.cdc.gov/nccdphp/brfss/.

Visits to the Dentist Grading Scale

Percentage of Adults, Ages 18 and Older, With an Annual Income of Less Than $15,000, Reporting a Visit to a Dentist or Dental Clinic; Percentage of Adults, Ages 18 and Older, With an Annual Income of $15,000 or More Reporting a Visit to a Dentist or Dental Clinic; Percentage of All Adults, Ages 18 and Older, Reporting a Visit to a Dentist or Dental Clinic in the Past Year

A	79% - 100%	D	43% - 54%
B	67% - 78%	F	0% - 42%
C	55% - 66%		

Dental Insurance Status of Adults and Dental Insurance Status of Elderly

Private medical insurance is the gateway to medical care for most Americans. This category measures the percentage of adults, 18 and older, in each state without dental insurance coverage. Grades are based on the percentage of self-reported adults without dental insurance.

Source: Behavioral Risk Factor Surveillance System (BRFSS), 1998, http://www.cdc.gov/nccdphp/brfss/.

Older people often have special oral health needs. As Medicare provides minimum adult dental coverage, this measure examines the percentage of people age 65 and over without dental insurance. Grades are based on the percentage of self-reported elderly without dental insurance.

Source: Behavioral Risk Factor Surveillance System (BRFSS), 1998, http://www.cdc.gov/nccdphp/brfss/.

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Dental Insurance for Adults and the Elderly Grading Scale

Percentage of Self-Reported Adults Without Dental Insurance; Percentage of Self-Reported Elderly Without Dental Insurance

A	0% - 37%	D	54% - 61%
B	38% - 45%	F	62% - 100%
C	46% - 53%		

ORAL HEALTH LEADERSHIP

Dental Director

The presence of a full-time state dental director, especially one who is a dental professional, can indicate the state government's commitment to addressing oral health needs and its understanding that oral health is a critical part of overall health. Grades are based on the presence of a dental professional (dentist or dental hygienist) serving as state dental director, and whether he/she is full-time.

Source: Association of State and Territorial Dental Directors Membership Listing, www.astdd.org.

Dental Director Grading Scale

A	Full-Time Dental Director—must be a dental professional
C	Part-Time Dental Director/or a full-time, non-dental professional
F	No Dental Director

Oral Health Coalition

Grades are based on the presence of an oral health coalition in the state. A coalition is defined as a group of individuals/organizations, including dental and non-dental professionals, seeking to improve oral health through advocacy, public awareness, and education. Factors that affect grades are the size and scope of the coalition, and how recently it met.

Source: State Dental Health Programs.

Oral Health Coalition Grading Scale

An independent panel assigned grades based on the presence and scope of the oral health coalition. Scores are given for the presence of a coalition, whether or not there is non-dental representation, how recently the coalition met, and how often the coalition meets.

ORAL HEALTH STATUS

Oral Health of Children

Good oral health begins with proper prenatal care. Steps taken early on can ensure a lifetime of healthy teeth and gums. However, poor dental habits too often begin in childhood and continue to old age. It is important to regularly measure the oral health status of children, which is not uniformly done, or not done at all in some cases, across the country. Grades for this category are based on whether or not a state has collected statewide baseline data on children's oral health and how recently data were collected. State legislatures should be encouraged to support funding for periodic surveys of oral disease prevalence among different age groups to provide a reliable national data set.

Source: State Dental Health Programs.

Oral Health of Children Grading Scale

An independent panel assigned grades based on whether or not statewide baseline data on caries prevalence among children were collected and how frequently data were collected.

Use of Spit Tobacco

Spit tobacco use can lead to nicotine addiction, gum recession, tooth decay, and oral lesions, and can cause oral cancer. Grades are based on the percentage of high school males who used spit tobacco in the 30 days prior to the survey. This category, like the category for sealants, is difficult to grade because of differing practices in gather-

ing data among the states. All states should utilize the same model to track spit tobacco use on a routine basis to provide a uniform measurement of spit tobacco use across the country.

Source: Youth Risk Behavior Survey (YRBS), 1999, 1998, and 1997 (http://www.cdc.gov/nccdphp/dash/yrbs/index.htm); Youth State Tobacco Activities Tracking and Evaluation System, 1999; State Survey Information.

Use of Spit Tobacco Grading Scale

Percentage of High School Males Who Used Spit Tobacco in the Past 30 Days

A	0%	D	20% - 29%
B	1% - 10%	F	30% - 100%
C	11% - 19%		

Edentulous Elderly

Grades for this category are based on the percentage of people 65 and older without any natural teeth. As with the "Dental Visits" category, three grades are given to highlight the difference in status for those of lower and higher incomes and the overall status of elderly in any given state.

1. The percentage of people 65 and older who have no natural teeth and have an annual income of less than $15,000;
2. The percentage of people 65 and older who have no natural teeth and have an annual income of $15,000 or more; and
3. The percentage of all people 65 and older without any natural teeth.

Edentulous Elderly Grading Scale

Percentage of People 65 and Older who have No Natural Teeth and Have an Annual Income of Less than $15,000; Percentage of People 65 and Older who have No Natural Teeth and an Annual Income of $15,000 or More; Percentage of All People 65 and Older Without Any Natural Teeth

A	0% - 14%	D	39% - 50%
B	15% - 26%	F	51% - 100%
C	27% - 38%		

Source: Behavioral Risk Factor Surveillance System (BRFSS), 1999, http://www.cdc.gov/nccdphp/brfss/.

Oral Cancer Mortality Rates

Approximately 30,000 new cases of oral cancer are diagnosed and over 8,000 people die each year from oral cancer. If detected early, mortality rates for oral cancer can be lowered significantly. Grades for this category are based on the average annual age-adjusted mouth and throat cancer mortalities per 100,000 people, based on data from the North American Association of Central Cancer Registries. Grades are based on the mean for each gender in all 50 states and the District of Columbia.

Source: North American Association of Central Cancer Registries-Seer Cancer Statistics Review (1994-1999), http://seer.cancer.gov/Publications/CSR1973_1998/oralcav.pdf.

Oral Cancer Mortality Grading Scale (Male)

Average Mouth and Throat Cancer Mortalities per 100,000 People

A	0 - 2.5	D	5.6 - 7.0
B	2.6 - 4.0	F	7.1+
C	4.1 - 5.5		

Oral Cancer Mortality Grading Scale (Female)

Average Mouth and Throat Cancer Mortalities per 100,000 People

A	0 - 1.0	D	2.3 - 2.8
B	1.1 - 1.6	F	2.9+
C	1.7 - 2.2		

FINAL GRADES

State Grades

Final grades were assigned to each state using an average of the independent variables rated. The final numeric grade was assigned a corresponding letter grade according to the grading scale outlined in the introduction of this report card.

Final Grades

	PREVENTION	Fluoridation	Sealants	ACCESS TO CARE	Availability of Dentists	Children's Medicaid Dental Program	Visits to Dentists- Income Less Than $15K	Visits to Dentists- Income More Than $15K	Overall Visits	Dental Insurance- Adults	Dental Insurance- Elderly	ORAL HEALTH LEADERSHIP	Dental Director	Oral Health Coalition	ORAL HEALTH STATUS	Oral Health of Children	Use of Spit Tobacco	Edentulous Elderly- Income Less Than $15K	Edentulous Elderly- Income More Than $15K	Edentulous Elderly- Overall	Oral Cancer- Male	Oral Cancer- Female	STATE GRADE
ALABAMA	B	B	B	D+	D	C	F	B	C	C	F	A	A	A	C	A	D	D	B	C	C	B	C
ALASKA	D	D	D	C+	B	C	F	B	B	A	C	B	C	A	C	C	D	C	B	B	B	C	C
ARIZONA	F	D	F	C-	F	C	D	B	C	B	D	A	A	A	B	A	B	B	B	B	B	B	C+
ARKANSAS	D	D	D	D	F	C	F	C	C	D	F	A	A	A	C	A	C	F	B	C	C	B	C-
CALIFORNIA	F	F	D	C	C	C	D	B	B	B	C	D-	F	D	B-	C	B	C	A	B	B	B	C
COLORADO	C	C	C	C-	C	C	D	B	B	I	F	A	A	A	C+	A	D	D	B	B	B	B	C+
CONNECTICUT	C+	B	C	C+	B	C	C	A	B	I	F	B	C	A	B	A	B	B	B	B	B	B	B-
DELAWARE	C	B	D	C-	D	D	D	B	B	I	I	B+	A	B	C+	C	B	C	B	B	C	B	C+
DIST. OF COLUMBIA	C	A	F	C+	A	D	C	B	B	I	I	F	F	DNR	C-	DNR	B	D	B	B	F	D	C
FLORIDA	C	D	B	C-	D	C	D	B	B	I	F	A	A	A	C+	C	B	C	A	B	C	C	C+
GEORGIA	C	A	F	D+	F	D	F	B	C	A	F	A	A	A	C	B	D	D	B	C	C	B	C
HAWAII	D	F	D	B-	B	C	C	B	B	A	B	A	A	A	B	A	B	C	A	B	C	B	B-
IDAHO	C	F	A	D+	D	I	D	B	C	C	F	A	A	A	C+	A	D	D	B	B	B	B	C
ILLINOIS	B	A	C	C	C	C	D	B	B	B	F	A	A	A	C+	B	C	C	B	B	C	B	C+
INDIANA	B	A	C	C-	D	C	D	B	B	B	F	A	A	A	C+	A	C	D	C	C	B	B	C+
IOWA	B+	A	B	C-	C	C	D	B	B	C	F	A	A	A	B-	A	C	C	B	B	B	B	B-
KANSAS	C	D	B	D+	D	I	D	B	B	I	F	C	F	A	C	F	C	C	B	B	B	B	C
KENTUCKY	C	A	F	C-	C	B	F	B	C	I	F	A	A	A	C	A	D	D	C	D	C	B	C
LOUISIANA	D+	D	C	D+	D	C	F	B	C	I	F	C	F	A	C	A	C	D	B	C	C	C	C-
MAINE	C+	C	B	D+	D	I	D	B	B	D	F	B	C	A	C+	A	B	F	C	C	B	B	C
MARYLAND	C+	A	D	C-	C	D	D	B	B	I	D	A	A	A	C+	A	B	D	B	B	C	C	C+
MASSACHUSETTS	D	D	D	C	B	B	C	B	B	C	F	D+	C	D	C+	F	B	C	B	B	B	B	C
MICHIGAN	B	A	C	C	C	C	D	A	B	I	D	C+	A	D	C+	C	C	D	B	B	B	B	C+
MINNESOTA	C	A	F	C	C	C	D	B	B	I	I	A	A	A	C+	C	C	D	B	B	B	B	C+
MISSISSIPPI	F	F	F	D	F	C	F	C	C	I	F	B	C	A	C+	A	C	C	C	C	C	B	C-
MISSOURI	D+	B	F	D	D	D	F	C	C	I	F	A	A	A	C+	A	C	F	B	C	B	B	C
MONTANA	D+	F	B	D+	C	C	D	C	C	D	F	A	A	A	C-	C	F	D	B	C	B	C	C-
NEBRASKA	D	C	F	C	C	B	C	B	B	I	F	A	A	A	C	D	D	F	B	C	B	A	C
NEVADA	C+	C	B	D+	F	C	D	C	C	I	D	B	C	A	B-	A	C	D	A	B	B	B	C
NEW HAMPSHIRE	F	F	D	C	C	I	C	B	B	I	F	A	A	A	C+	A	B	D	B	B	C	C	C
NEW JERSEY	F	F	D	C-	B	D	D	B	B	I	F	B	C	A	C+	F	C	C	A	B	B	B	C
NEW MEXICO	C+	C	B	D+	F	C	D	B	C	I	F	A	A	A	C+	A	C	D	B	C	B	B	C
NEW YORK	C	C	C	C	B	I	D	B	B	B	F	A	C	A	B-	B	B	D	B	B	B	B	C+
NORTH CAROLINA	C+	B	C	C-	F	C	D	B	B	I	I	A	A	A	C+	A	C	D	B	B	C	B	C+
NORTH DAKOTA	B+	A	B	D	D	D	D	B	C	D	F	B	C	A	C	A	D	F	C	D	B	B	C
OHIO	B	B	B	C-	C	C	D	B	B	C	F	B	A	C	B-	A	C	D	B	B	B	B	C+
OKLAHOMA	D+	C	D	D	D	D	F	C	C	I	F	A	A	A	C	A	D	F	C	C	B	B	C-
OREGON	D	F	C	C	C	C	D	B	B	B	F	A	A	A	B-	A	C	C	B	B	B	C	C+
PENNSYLVANIA	D+	D	C	C-	C	C	D	B	B	I	F	A	A	A	C	A	D	D	C	C	B	B	C
RHODE ISLAND	B	B	B	C	C	C	C	B	B	B	F	A	A	A	C+	C	B	D	B	B	B	B	C+
SOUTH CAROLINA	A	A	A	C-	F	C	D	B	B	I	I	A	A	A	C-	C	C	D	B	C	D	C	C+
SOUTH DAKOTA	B	B	B	D+	D	I	D	B	C	I	F	F	F	F	C+	A	D	D	B	C	B	B	C-
TENNESSEE	C	A	F	C-	D	C	D	B	B	I	F	A	A	DNR	C	DNR	D	F	B	B	C	B	C
TEXAS	D+	C	D	D	D	I	F	C	C	C	F	A	A	A	B	A	C	B	A	B	C	B	C
UTAH	C	F	A	C	C	D	C	B	B	B	F	A	A	A	B	A	B	C	B	B	A	A	B-
VERMONT	C	D	B	C	C	B	C	B	B	C	F	A	A	A	C+	B	C	D	B	B	B	B	C+
VIRGINIA	B+	A	B	C	C	C	D	B	B	B	F	A	A	A	C+	A	I	F	B	C	C	B	C+
WASHINGTON	C	D	B	C	C	I	D	B	B	B	F	B	C	A	B-	A	C	D	B	B	B	B	C+
WEST VIRGINIA	B	B	B	D	D	C	F	C	C	I	F	B	C	A	C	A	D	F	C	D	B	B	C-
WISCONSIN	C+	B	C	C	C	C	D	B	B	B	F	A	A	A	C+	B	D	C	B	B	B	B	C+
WYOMING	C	F	A	D+	D	C	D	C	C	C	F	B	C	A	C+	A	D	F	B	B	A	B	C
UNITED STATES	C			C-								B+			C+								C

2-11

National Grade

The final national grade is an average of all the state grades. The final national average was assigned a corresponding letter grade according to the grading scale outlined in the introduction of this report card.

For more information and links to state oral health initiatives, visit www.oralhealthamerica.org.

2-12

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

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House Committee on Health and Human Services
February 25, 2002
1:30pm

RESPONSE TO REQUEST FOR INFORMATION ABOUT HEALTH CARE SERVICES

Health Care Policy
Laura Howard

HsHHS
2-25-02
Atch # 3

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

House Committee on Health and Human Services
February 25, 2002 1:30PM

RESPONSE TO REQUEST FOR INFORMATION ABOUT HEALTH CARE SERVICES

Mr. Chairman and members of the Committee, I am Laura Howard, Assistant Secretary for Health Care Policy with the Kansas Department of Social and Rehabilitation Services. I appreciate the opportunity to testify before you today in response to your inquiry regarding health care services provided by SRS, and the associated costs of these services. SRS is a key purchaser of health care services for Kansas citizens. More than 200,000 Kansans will access services for acute health care needs through the Medicaid program and the State Children's Health Insurance program this year. SRS also plays a key role in the provision of long-term care services for persons with disabilities, primarily through our home and community based services waiver programs. These programs provide attendant care and related services to enable individuals to remain in their homes; the acute medical needs are paid through the regular medical assistance component of the Medicaid program. This presentation will focus primarily on health coverage for acute health care needs; the long-term care component is discussed primarily in relation to costs associated with acute health care needs of beneficiaries.

The Medicaid Program

The Medicaid program is a joint federal and state partnership that provides essential medical and medically related services to the most vulnerable populations. It is the third largest source of health insurance in Kansas, covering more than 200,000 persons monthly. In general, Medicaid provides three types of health coverage: health insurance, supplemental health insurance coverage, and long term care. The health insurance covers low income families with children and people with disabilities. Supplemental health insurance covers low income Medicare beneficiaries for services not covered by Medicare (e.g., out-patient prescription drugs) and Medicare cost-sharing (e.g., premiums and deductibles).

Medicaid has become one of the largest single components of state budgets across the nation. In 1999 Medicaid expenditures comprised nearly 14 percent of all states' spending and accounted for 43 percent of all federal funds provided to the states. In FY 1996, the Medicaid budget for Kansas accounted for 7.8 percent of the total budget. By FY 2001, Medicaid expenditures accounted for 14.8 percent of the State's budget. Much of this growth is due to an effort to maximize federal dollars in order to provide services to the State's most vulnerable and needy citizens.

National Medicaid expenditures increased 14 percent this year and are projected to grow by 8.8 percent in the next fiscal year. Kansas Medicaid expenditures are projected to increase by

14 percent in the current fiscal year. In addition, with the implementation of the proposed cost containment plan described later in the document, regular medical expenditures are projected to grow by 9.2 percent in FY 2003.

A number of studies have indicated that individuals who do not have health insurance often forgo preventative health care and when faced with a significant health crisis will access care in the most expensive setting, emergency rooms. In addition, there is strong evidence that health outcomes are greatly improved when individuals have regular access to a medical home. This is especially true for pregnant women and children. The goal of the Kansas Medicaid program; whether in HealthConnect, the primary care case management program, or the blended Title XXI and XIX program known as HealthWave, a capitated managed care program; is to create a medical home for the beneficiary. This medical home serves to promote access and coordination of care.

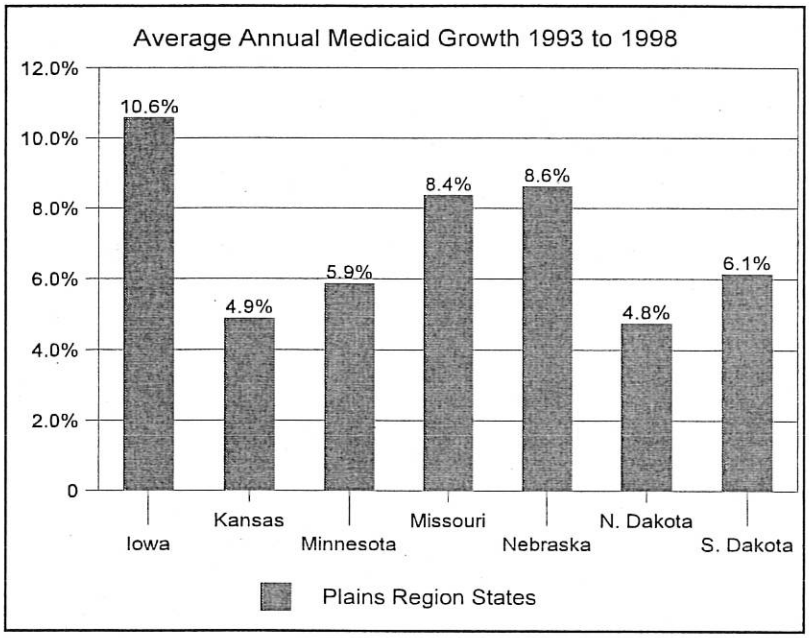
The Health Care Market

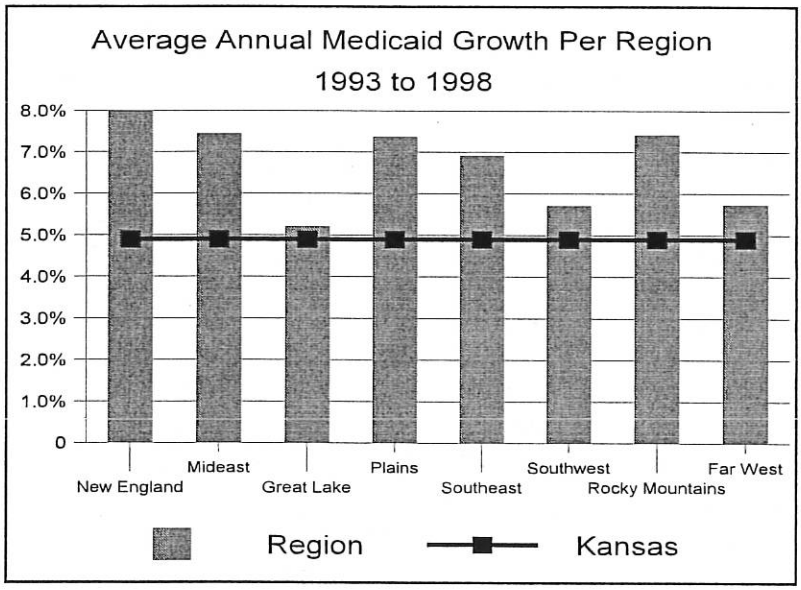
As a public purchaser of health care, Medicaid operates in the health care marketplace like any other health insurance organization. Because it purchases within this market, it is subject to the same economics that affect other health insurance providers. The inflationary forces that influence pricing in the private market impact the Medicaid program. For example, advances in pharmaceuticals and the accompanying price increase for newer and better drugs have influenced both privately and publicly funded health insurance costs.

For both public and private programs, managing the cost increases in health care is becoming one of the most difficult tasks in the provision of health coverage. Predictions for the future of the health care system do not paint an optimistic picture. The slow-down in the growth of health care costs witnessed in the mid to late 1990's has come to an end. In a report released by the Federal Centers for Medicare & Medicaid Services (CMS, formerly known as HCFA) from a comprehensive study of the entire health care industry, Katherine Levit, Director of National Health Statistics for CMS, predicted "a stronger increase in the health spending share of gross domestic product in the near future." This report also indicated that a substantial cause of this spending increase results from consumers,' doctors,' and hospitals' opposition to managed care. While hospitals have gained an increase in bargaining power by forming consolidated systems and networks, consumers have indicated their disfavor for more cost-efficient but more restrictive managed care models.

In addition, national employer-provided health insurance premiums have been predicted to increase by 13 percent this year with no slow down in cost increases in sight. The cost of Kansas' Public Employee Health Insurance is projected to increase by 25 percent. Moreover, the CMS report noted above indicated that the rise in health care benefit costs may discourage employers from offering their employees health insurance altogether. The combination of medical cost inflation and a slowing of the economy is likely to result in a significant increase in the number of uninsured Americans - already estimated at almost 40 million persons in 2001. This increase in the uninsured population will substantially raise the pressure to expand publicly

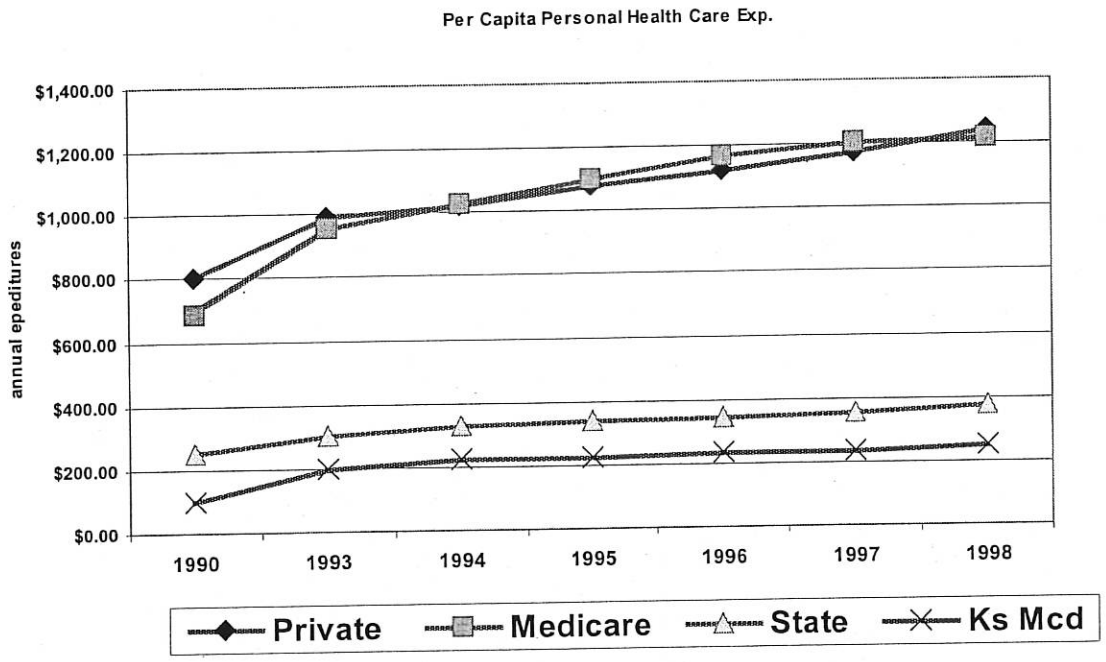
funded coverage and it will place significant demand on the provider community to deliver more uncompensated care. The following two graphs demonstrate the average annual Medicaid growth for states in the plains region and compares Kansas' average annual Medicaid growth to that in other regions.





New England	7.98%	Southwest	5.70%
Mid East	7.44%	Rocky Mountains	7.42%
Great Lakes	5.22%	Far West	5.73%
Plains	7.37%	Kansas	4.89%
Southeast	6.91%		

The following chart shows the per capita payments for personal health care services by payment source for 1990, and 1993 through 1998. The chart compares average annual payments per consumer for private (commercial) insurance, Medicare, Kansas Medicaid, and all other state Medicaid programs. Personal health care services include physician, inpatient, outpatient, pharmacy, dental services, and medical equipment. According to these statistics, the average payment for individuals has increased each year for all payment sources. Medicare and commercial payments are higher and have increased more than Medicaid. In addition, Kansas Medicaid has lower per-person expenditures but the growth trend closely mirrors the national Medicaid average. These data are from the Center for Medicare and Medicaid (formerly HCFA) data tables found at www.hcfa.gov/stats.



Within this context, the publicly funded programs (i.e., Medicaid, State Children's Health Insurance Program (SCHIP), and MediKan) will need to move more aggressively from bill paying to value-based purchasing. Doing so will require these programs to continue to examine what coverage to provide, who should provide the coverage, and what the relative benefit-to-cost ratio is for specific medical services. Medicaid is unable to mirror the commercial health market in seeking to control cost growth by restricting certain benefits with rigorous medical necessity tests and by increasing the liability of the beneficiary through increased deductibles and co-pays.

Overview of Health Programs Offered

The following health programs are administered by SRS' Medical Policy/Medicaid section. Combined, they serve more than 200,000 persons. The specific services provided and the people served are described in more detail later in this paper.

HealthConnect

HealthConnect, a managed care program, serves over 71,000 Kansans in all 105 counties in Kansas. It is Medicaid funded at a 60/40 federal/state match rate. The purpose of the HealthConnect program is to create for each beneficiary a "medical home" to assure continuity of care. Each beneficiary is assigned to a primary care physician who coordinates the patient's medical care and makes referrals to specialists when appropriate.

HealthWave

HealthWave is also a managed care program. It differs from HealthConnect in that it combines the State Children's Health Insurance Program (Title XXI) with Medicaid managed care (Title XIX) to provide coverage for children who reside in households with an income less than 200 percent of the federal poverty level. It also provides coverage for eligible parents of these children and for adults who are eligible for Medicaid. (It should be noted that adults who have children enrolled in either program are only eligible if their income is at or below 34 percent of the federal poverty level, which for a household of three is just over $5,500 dollars). This family coverage is provided in a capitated format in which the State contracts with a Managed Care Organization, FirstGuard Health Plan Kansas, Inc. (FirstGuard), to provide a full array of physical health services. There are currently over 72,000 children and adults enrolled in this health plan. The State contracts with the Mental Health Consortium for mental health services, and with Doral Dental for dental services for children. Of these, 49,000 are Title XIX eligible and an additional 23,000 are Title XXI eligible. Title XIX eligibles are funded at 60/40 federal match rate and Title XXI children are funded at a 72/28 federal match.

In 1998, the legislature established the State Children's Health Insurance Program and required that all services be provided in a capitated managed care format. The program was initiated in January of 1999 with contracts to two managed care providers and with a single contract awarded to the mental health consortium to provide for managed behavioral health care. In the spring of 1999, Horizon Health was declared insolvent and the network was taken over by FirstGuard Health. Contracting with managed care organizations such as FirstGuard allows the state to

provide a health plan that can work with providers to assure better health outcomes. These include implementation of disease management programs and, in the case of FirstGuard, case management for pregnant women who are identified as being potentially at risk for a poor birth outcome. The program includes a managed behavioral health contractor, the Mental Health Consortium, and a managed entity for dental services, Doral Dental.

In the fall of 2000, SRS issued a Request for Proposals for the blended Title XIX and XXI program that would offer a single health plan for eligible families. Kansas received only one bid for the program, this bidder was FirstGuard Health Plan. Simultaneously, Kansas, at the request of the Centers for Medicare and Medicaid Services, rebased its capitated managed care rates. This rebasing involved the use of prior claims data to actuarially determine the cost of various medicaid populations. This rebasing led to an increase in managed care rates of approximately 15 percent. These rates vary according to the age and locale of the service. The variation in rates is based on the fact that various age groups have differential costs because of variations in utilization. In addition there are variations in costs depending on the location of the service provider. The final contract for the blended program was signed in late spring 2001. The program was fully implemented in October of 2001.

Fee For Service

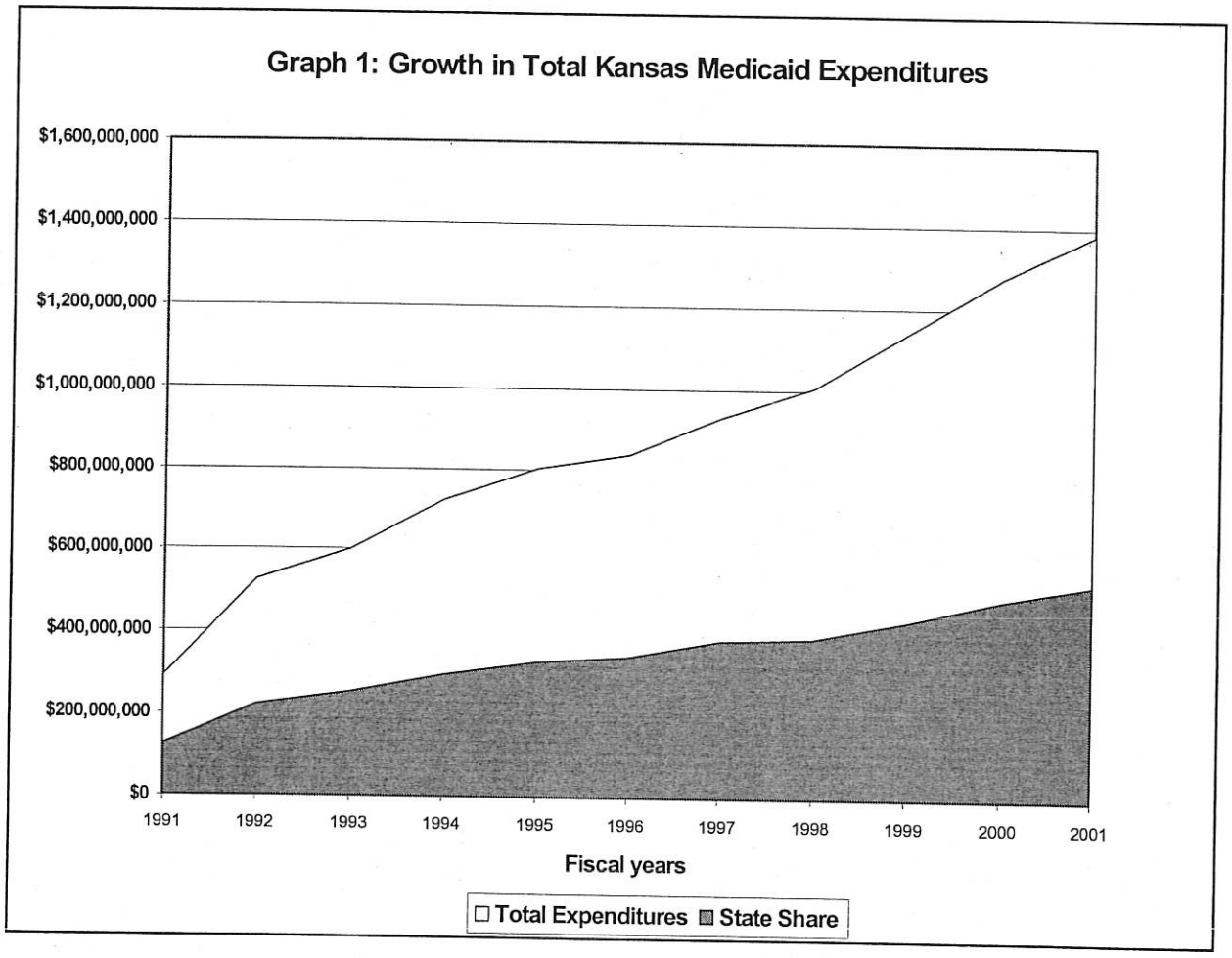
Over 85,000 beneficiaries are currently in a Medicaid-funded fee-for-service program. Most of these individuals are ineligible for managed care, both the primary care case management and risk based managed care models. Some portion of these, however, are new to Medicaid and are eligible for managed care, but have not yet made a choice; they may remain in fee for service for one or two months. The fee-for-service population includes persons on the Home and Community Based Services (HCBS) waivers, residents of nursing facilities, SSI recipients, and persons who have medical spend down issues. Their coverage is the same as found in the other federally matched programs with the exception that they are not required to receive a referral from a primary care physician for a specialist services.

MediKan

The MediKan program currently covers adults who are seeking Social Security disability determination. There are almost 3,000 MediKan beneficiaries enrolled in this program. MediKan covers a limited array of medical services and is generally considered interim coverage for individuals awaiting determination from the Social Security Administration that would make them eligible for Medicaid. MediKan is funded with state general fund dollars.

Historical Trends

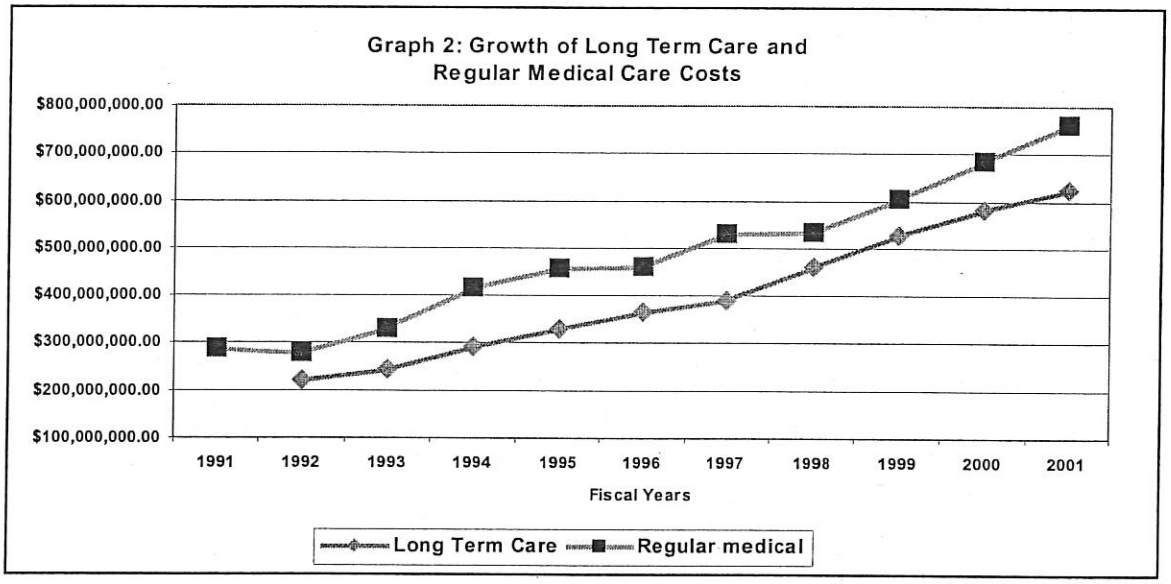
The graph below shows the growth in total Medicaid expenditures in Kansas for the last ten fiscal years. [1] During this time period the entire Medicaid program has grown at an annual rate of nearly 9.9 percent. Much of this growth is the result of policy decisions regarding how the State pays for programs designed to meet the needs of some of the State's most vulnerable and needy citizens.



Graph 2 traces the last ten years of growth for long term care (i.e. nursing facilities and Home and Community Based Services), and regular medical costs. Long term care coverage supports

[1] The shaded portion of the graph represents the state match. While the federal match is set at near 60 percent the actual match of state general fund dollars is slightly less than the calculated match of nearly 40 percent because nearly $72,000,000 federal funds are matched with local dollars using a process known as certified match. Mental health, local education agencies, and developmental disability services receive Medicaid funds through this procedure.

older Americans and individuals with disabilities. Expansion of community-based, long term care programs has resulted in substantial cost increases in the regular medical budget, for two reasons. First, substantial increases in the number of beneficiaries occur because these programs draw in far more beneficiaries than the number who were previously served by institutional programs. Individuals who could have received care in these institutional facilities, but chose not to, are more likely to take advantage of community-based funding alternatives, such as home and community based services (HCBS) waivers. Second, the populations served by these programs have very high medical expenses--far higher than the average Medicaid population. Thus, increasing the number of people served by long term care also drastically increases medical expenses.



Each state establishes under federal guidelines its own eligibility standards, benefits package, payment rates and program administration. While the guidelines allow states flexibility in establishing eligibility standards and in defining the benefits package, they also require all participating states to provide certain identified services (See Table 1) and to cover specified populations (See Table 2).

TABLE ONE
Mandated and Optional Services

Federally Mandated Services[2]	State Optional Services
Early and periodic screening and diagnosis and treatment (EPSDT) for children. Also known as KAN Be Healthy. All medically necessary services are covered, but services not normally covered under the Medicaid State Plan require prior authorization.	**Alcohol and Drug Abuse Treatment**
Emergency Medical Services for Alien Individuals	**Attendant Care for Independent Living**
Family Planning Services and Supplies	**Audiological Services**
Home Health Services	**Behavior Management**
Inpatient General Hospital Services	**Community Mental Health Center and Psychological Services**
Laboratory and X-Ray Services	**Dental Services.** Limited to KAN Be Healthy consumers (children), except for medically necessary extractions.
Medical Transportation	**Durable Medical Equipment, Medical Supplies, Orthotics, and Prosthetics**
Outpatient General Hospital Services	**Early Childhood Intervention**
Physician Services. This includes pregnancy related services, and some physician extender (i.e., nurse-midwife and nurse practitioner) services.	**Health Clinics**
	Home or community-based services
	Hospice Services
	Inpatient Psychiatric Services. For individuals under age 21
	Intermediate care facility (ICF/MR) services
	Local Education Agencies
	Local Health Department Services
	Nursing Services (ARNP)
	Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders.
	Prescribed Drugs
	Podiatric Services
	Respiratory care for ventilator-dependent individuals.
	Services for Special Disorders
	Targeted Case Management for Assistive Technology
	Vision Services

[2] Federal rules require that when services are reduced or eliminated, they must be reduced or eliminated for all adults covered by Medicaid. However, federal rules for Early Periodic Screening, Diagnostic, and Treatment do not allow for significant reduction or elimination of medically necessary services for children.

Each service is provided only when medically necessary to the beneficiary. In addition, each provided service must be defined in the Kansas State Plan.

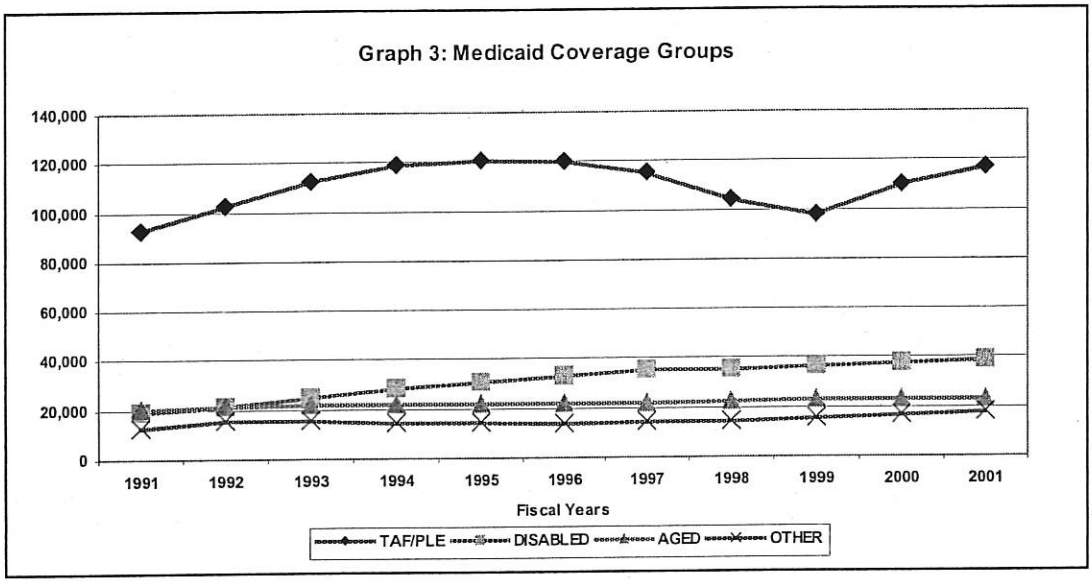
TABLE TWO
Mandatory and Optional Coverage Groups

Mandatory Coverage Groups	Optional Coverage Groups
State Medicaid programs must cover the following groups of people, including the key populations of people who receive cash assistance from Temporary Assistance to Families (TAF) or Supplemental Security Income (SSI) and additional groups of children and pregnant women.	"States also have the option to provide Medicaid coverage for other "categorically needy" groups. These optional groups share characteristics of the mandatory groups, but the eligibility criteria are somewhat more liberally defined." http://www.hcfa.gov/medicaid/meligib.htm The following are the major optional populations covered in Kansas.
People who are eligible for TAF (34 percent of the federal poverty level adults). **People who receive SSI.** Also referred to as the portion of the Medicaid program that serves "aged, blind or disabled" individuals, federal SSI status is based on age, disability and income (74 percent of the federal poverty level). **Pregnant women** and children under age one whose family income is up to 150 percent of federal poverty guidelines. Pregnant women are covered for pregnancy-related services, through about 60 days after delivery. **Infants born to Medicaid-eligible pregnant women.** For one year. **Children under age 6** whose families earn up to 133 percent of poverty. **Children ages 6-18** whose family income is up to 100 percent of federal poverty level. **Children who receive adoption assistance or foster care.**	**Children** under age 21 who meet certain income and resource requirements under Aid to Families with Dependent Children (AFDC) guidelines as they existed prior to welfare reform but who otherwise are not eligible for AFDC. This group consists primarily of youth aged 18 to 21. **Certain institutionalized individuals.** This includes people in hospitals, skilled nursing facilities and intermediate care facilities for people with mental retardation or related conditions, who would otherwise be eligible for TAF or SSI, including those with incomes up to 300 percent of SSI payments. It also includes children under age 18 after 30 days of continuous institutionalization, regardless of parental assets and income. **Home and community-based services waiver recipients.** These individuals must meet both income and medical criteria for institutionalization (100 percent of the federal poverty level).

Mandatory Coverage Groups	Optional Coverage Groups
Some Medicare recipients. State Medicaid programs must pay Medicare premiums, deductibles and co-payments for elderly and disabled people with incomes below poverty. **Special protected groups**. States must cover certain special groups who may keep Medicaid for a period of time. For example, they must provide short-term coverage for people who lost SSI eligibility because of increased wages or Social Security payments.	**"Medically needy" people**. States may set Medicaid income eligibility standards at levels that permit coverage of people who do not qualify for cash assistance, but who meet categorical standards (such as for children, pregnant women, or the disabled). The optional income ceilings may not be higher than 133 1/3 percent of the state's TAF payment. This coverage is provided to people who have large medical expenses that consume so much of their income that they "spend down" to the level that would qualify them for Medicaid. In Kansas, the income limit is based on the SSI payment standard and is approximately $500 per month. **Breast and Cervical Cancer.** Kansas women with a qualifying income who are found in need of treatment by KDHE's Free to Know Program can now receive full Medicaid benefits. (The Free to Know Program is a part of the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program). The women must (a) be un- or under- insured, (b) have an income below 250 percent of the federal poverty level, ©) have a pre-cancerous or early stage cancer condition, and (d) be between the ages of 40 and 65. **Working Healthy.** Persons aged 16 to 64 who are employed and disabled. This program will begin in July 2002. Ultimately, there will be two optional coverage groups for this category. The first group will cover persons who meet Social Security disability criteria. The second group will cover individuals who are employed at a minimum of 40 hours per month and have experienced a "medical improvement" to the extent that disability status is no longer met.

Population Growth and Costs

Approximately one-half of the Medicaid dollar growth from 1991 to 2001 was attributable to actual caseload increases (i.e. growth in the number of beneficiaries). Population growth was seen primarily among those people who are Aged or Disabled and people who meet certain poverty level guidelines (TAF/PLE). The Aged and Disabled populations grew at a proportionately faster rate than the TAF/PLE population, increasing by 54 percent during the period of FY 1991-FY 2001 (See Graph 3 below). In addition, within the Aged and Disabled categories, the Disabled population comprised 73 percent of the growth due in large part to the expansion of waiver services. As discussed later in this paper, this growth is especially significant because the Disabled population typically has more substantial health issues with consequentially higher cost care.



The TAF/PLE populations grew most during the early 1990s as a result of federal mandates regarding the inclusion of certain populations as non-optional. For example, states were required to change the mandatory poverty levels to include more pregnant women and children. In FY 1996, TAF/PLE populations had a downturn in the number of enrollees resulting from the implementation of welfare reform. In FY 1999, this group demonstrated growth correlating with the beginning of the SCHIP program, known as HealthWave, because the SCHIP initiative included aggressive outreach activities and a simplified application process for both SCHIP and Medicaid eligible children. This simplified enrollment resulted in the identification of approximately 1.2 Medicaid children for each SCHIP-eligible child.

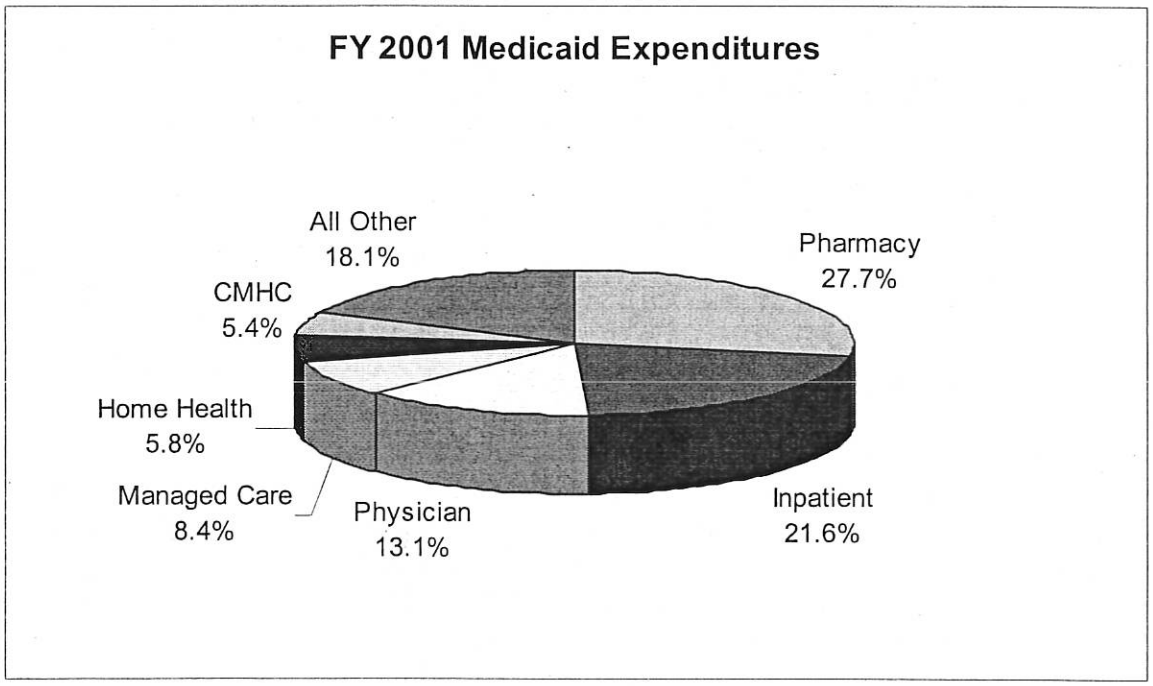
A significant disparity in expenditures exists between the TAF/PLE beneficiaries and the Aged and Disabled beneficiaries. While the TAF/PLE group comprises nearly 60 percent of the covered population, they account for less than 35 percent of the health care costs. These low costs are explained by the fact that children make up 81 percent of the total TAF/ PLE group. The average cost of health care for TAF/PLE beneficiaries has increased annually by 3.4 percent.

This cost is well below the rise in the consumer price index for the same period of time. Two reasons may account for this low rate of growth. First, a significant shift occurred in the last ten years in the population mix in the TAF/PLE group. This shift has resulted in a sizable reduction in the number adults receiving coverage and in an increase in children, who generally have low health costs. The second reason for the low inflation rate is the success managed care has had in ensuring more appropriate utilization of services.

On the other hand, the Aged and Disabled beneficiaries comprise less than 35 percent of the covered population but account for more than 60 percent of all medical expenditures for Medicaid, due to their high medical needs. Unlike the TAF/PLE population the Aged/Disabled costs have risen at an annual rate of almost 10 percent. In 1991, they comprised only 37 percent of the medical costs in Medicaid.

Medical Service Costs

About 84% of all medical expenditures in the Medicaid program are spent in six service areas: pharmacy, inpatient hospital, physician services, managed care, home health, and community mental health center (CMHC). Other funded services include dental, vision, audiology, rehabilitation therapies, medical transportation, durable medical equipment and school-based health services. The chart below illustrates the FY 2001 percentage of expenditures by program area.



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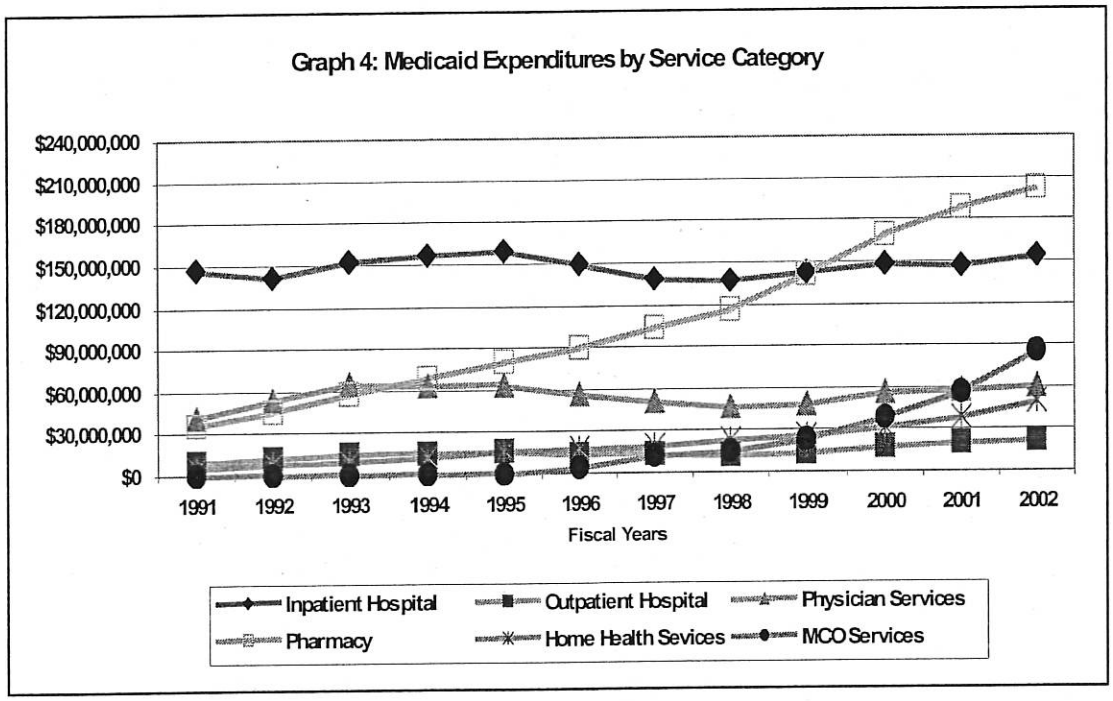
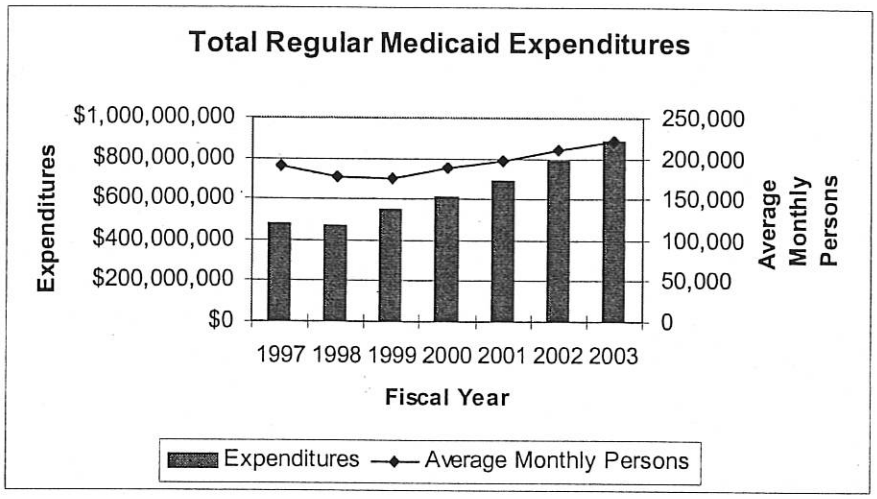
FY 1991 through FY 2002 projections (Graph 4) show that expenditures have increased at a yearly average of nearly 10 percent. The cost of pharmaceuticals, currently the largest category of expenditures in medical assistance, has had the most dramatic increase. These costs grew at an average annual rate of 16.0 percent between FY 1991 and FY 1997. Beginning in FY 1998 through FY 2001, pharmacy grew at 20.7 percent per year. Now, it appears that this accelerated growth has begun to slow in FY 2002 and in the projected estimates for FY 2003. The single fastest growing component of the medical services budget, in terms of percent change, is home health services. This component is expected to grow 47 percent over the next two fiscal years. Inpatient hospital and physician services have remained fairly stable over the same period. In FY 1991, inpatient hospital costs accounted for more than 55 percent of the total medical expenditures for the year, but they are projected to account for less than 35 percent of the total expenditures in FY 2002.

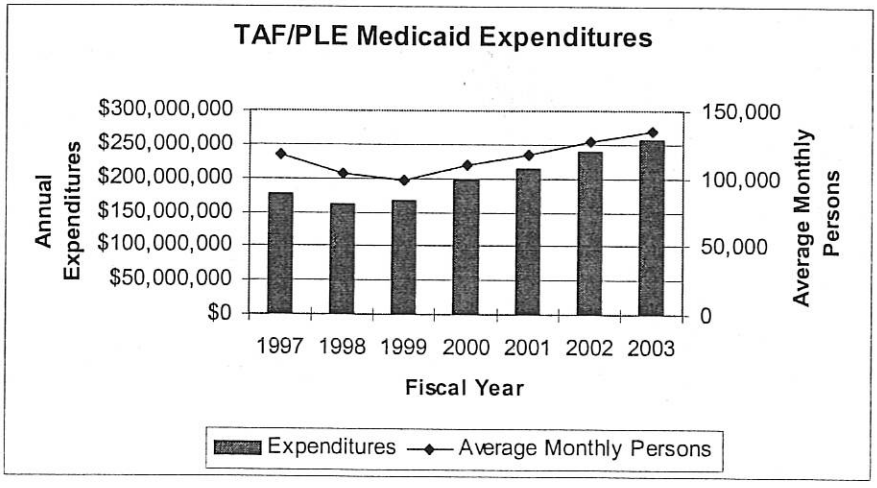


Cost increases in the Medicaid program have occurred for three reasons. First, expansion of services to new populations and growth in current eligible populations has occurred. For example, coverage was expanded to include women with breast or cervical cancer who earn less than 250 percent of the poverty level, and there was an increase in enrollment of poverty-level eligible children. Second, service utilization has increased. For instance, a recent increase in home health services is attributable to increased utilization; between FY 1998 and FY 2000 the number of beneficiaries accessing home health grew by only 22 percent while expenditures increased by 60 percent. Finally, there have been increases in pricing of service units, either because of rate adjustments as in increased fees or actual inflation in the market place, as found in the use of pharmaceuticals. For example, the average cost of a prescription in the Medicaid program increased from $30 in 1996 to $50 in FY 2002.



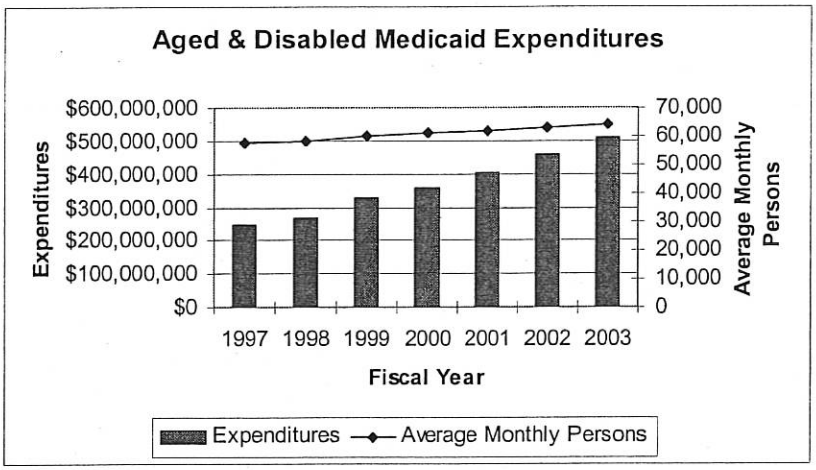
Fiscal Year	Average Monthly Persons	Percent Change	Average Cost per Person per Month	Percent Change	Expenditures	Percent Change
1997	189,582		$209		$475,930,000	
1998	177,579	-6.3%	$221	5.8%	$471,556,744	-0.9%
1999	173,998	-2.0%	$261	17.8%	$544,327,399	15.4%
2000	188,250	8.2%	$269	3.1%	$607,216,000	11.6%
2001	197,999	5.2%	$289	7.6%	$687,297,857	13.2%
2002	210,730	6.4%	$312	8.0%	$790,000,000	14.9%
2003	221,400	5.1%	$333	6.6%	$885,000,000	12.0%
Proposed Cuts					-$22,401,000	
GBR '03	221,400	5.1%	$325	3.9%	$862,599,000	9.2%

The increase in TAF/PLE populations is comprised primarily of increases in children who enroll as a result of the out-reach initiatives carried out for the SCHIP. Medicaid continues to experience about 1.2 eligibles for each SCHIP eligible child. Cost growth for this population remains low since they are low utilizers of medical services.



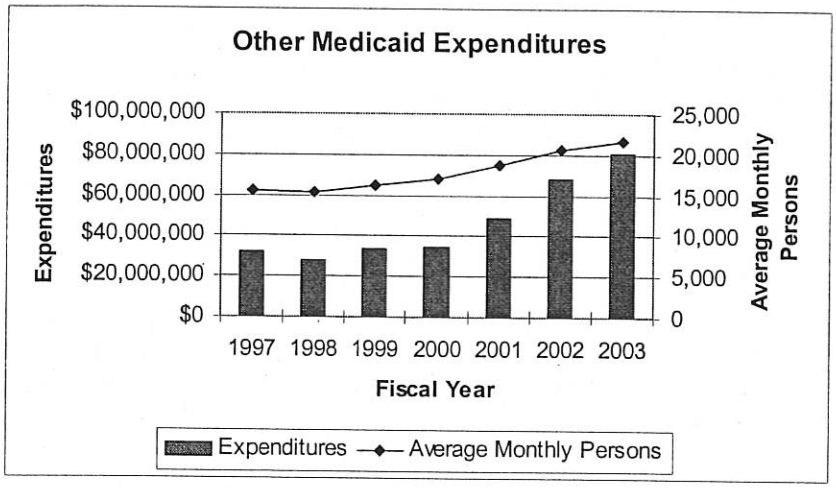
Fiscal Year	Average Monthly Persons	Percent Change	Average Cost per Person per Month	Percent Change	Expenditures	Percent Change
1997	116,662		$126		$176,083,967	
1998	103,744	-11.1%	$129	2.8%	$160,893,378	-8.6%
1999	97,727	-5.8%	$143	10.5%	$167,545,413	4.1%
2000	110,012	12.6%	$150	4.9%	$197,815,651	18.1%
2001	117,464	6.8%	$152	1.1%	$213,642,083	8.0%
2002	127,060	8.2%	$158	4.1%	$240,620,000	12.6%
2003	135,320	6.5%	$158	0.1%	$256,515,000	6.6%

While the population growth for the Aged and Disabled has been low during the last three years, their rate of utilization and the cost of services has increased dramatically. The percent of per-person cost increase from FY 2001 to projected FY 2003 is more than 20 %, during the same time period, the TAF/PLE per-person cost is expected to rise only 3.9%.



Fiscal Year	Average Monthly Persons	Percent Change	Average Cost per Person per Month	Percent Change	Expenditures	Percent Change
1997	57,440		$360		$247,920,483	
1998	58,525	1.9%	$380	5.6%	$266,647,026	7.6%
1999	60,118	2.7%	$451	18.7%	$325,233,343	22.0%
2000	61,150	1.7%	$490	8.7%	$359,656,514	10.6%
2001	61,928	1.3%	$544	11.0%	$404,257,552	12.4%
2002	63,120	1.9%	$603	10.8%	$456,740,000	13.0%
2003	64,380	2.0%	$656	8.8%	$506,915,000	11.0%

Within the other population category are children in foster care and adoption services, persons on MediKan, dually eligible persons and individuals brought back into the program because of CMS enforcement of 1931 rules. Specialized health care is provided at all State hospitals as an essential part of the services.



Fiscal Year	Average Monthly Persons	Percent Change	Average Cost per Person per Month	Percent Change	Expenditures	Percent Change
1997	15,480		$170		$31,549,600	
1998	15,310	-1.1%	$149	-12.1%	$27,413,000	-13.1%
1999	16,153	5.5%	$174	16.8%	$33,773,000	23.2%
2000	17,087	5.8%	$170	-2.4%	$34,852,600	3.2%
2001	18,607	8.9%	$219	29.0%	$48,955,057	40.5%
2002	20,550	10.4%	$277	26.6%	$68,430,000	39.8%
2003	21,700	5.6%	$309	11.5%	$80,540,000	17.7%

Managing Costs

Unlike a commercial health plan, federal rules and regulations limit the action the State can take to manage cost. Mandatory benefits and populations make cost containment difficult. In addition, some cost containment tools employed by commercial health plans, such as patient co-pays and deductibles, are limited or prohibited by Medicaid. Further, although reducing payments to providers is an option, it is a tool of limited utility because it would likely limit access to care by reducing the number of providers who are willing to participate in the Medicaid program.

While waivers have often been seen as a way to contain costs, they have more frequently been used for creative service delivery. Because many waivers fund long-term care for groups of people who account for a large percentage of other Medicaid costs, they have not been

completely successful as cost containment tools, although they have limited the growth of more expensive institution-based alternatives.

MEDICAID WAIVERS

The complex and often arcane rules and regulations under which the Medicaid program must operate can present barriers to the efficient operation of the program. The federal rules allow for states to waive specific provisions to those rules in order to provide services in alternative ways. For the Centers on Medicare and Medicaid Services (CMS) to grant a waiver, it must review the proposal to assure the guarantee of beneficiary protections and demonstration of budget neutrality. Waivers have generally provided services in more innovative ways than the traditional service models.

The two most common waivers are those granted for home and community based services (HCBS) waivers and waivers that allow the state to provide healthcare services in a managed care model. The HCBS waivers, known as 1915(c) waivers, waive the beneficiaries' right to receive services in an institutional setting. Managed care waivers, called 1915(b) waivers, waive the requirement that beneficiaries receive freedom of choice regarding which Medicaid provider they visit.

Another waiver, the 1115 demonstration waiver, allows states broad discretion in waiving certain requirements to allow for greater innovation. 1115 waivers require federal review to assure appropriate beneficiary protections and care. Like the 1915 waivers, demonstration waivers must meet strict budget neutrality tests for Federal approval to be granted.

Recently, CMS announced a new waiver process known as the Health Insurance Flexibility and Accountability (HIFA). Similar to an 1115 waiver, HIFA allows states creativity in their approach to health care delivery and coverage. It differs from the 1115 waiver in that it allows states to have flexibility in developing the benefit packages for optional populations, provided savings which accrue are used to expand coverage to new populations.

In the past, the Kansas Medicaid program attempted to manage costs by cutting benefits including eliminating heart and lung transplants, stopping adult dental services with the exception of extractions, and reducing pharmacy reimbursement in 2000.

Currently, the Medical Policy/Medicaid section engages in a number of activities designed to control the growth of medical costs. The activities include redefiniting medical necessity to establish that procedures and products must be both evidence-based and essential to the individual's physical health. The guiding principle has been: the appropriate service provided at the appropriate skill level. With this guideline in mind, the Medical Policy/Medicaid section has begun several initiatives designed to slow the growth of specific program areas.

Over the last several years, numerous cost containment activities have focused on the pharmacy program. Three activities are intended to address appropriate drug utilization:

- Mandated use of generic substitutes unless the physician has specifically ordered the brand name drug.
- Required prior authorization for some drugs before they can be dispensed. In these cases, therefore, physicians must assure that the patient's condition meets accepted clinical criteria determined by research to be appropriate for the use of the specific drug.
- Limited supply of 34 days per prescription filled. This helps to eliminate the costs of unused drugs that result from treatment noncompliance or medication changes associated with providers' attempts to find the most effective medication.

Other cost containment activities in the pharmacy program are designed to ensure appropriate pricing of products, including:

- Setting the maximum allowable cost (MAC) pricing so that it creates a price differential that is below the federal pricing guidelines, but still allows the pharmacist a reasonable return on their investment, and.
- Requiring pharmacists to credit back unused drugs dispensed to nursing home patients.

In addition, three other programs, home health, transportation, and MediKan, have been affected by cost containment operations. Home health has experienced a substantial increase in cost despite the low growth in the number of recipients. Analysis of the home health program has revealed that as much as 80 percent of the services provided were provided at an inappropriately high level of skill. That is, the majority of the consumers who received skilled nursing visits did not need skilled nursing care. To remedy this, the Medical Policy/Medicaid section has implemented a change in home health billing procedures. New codes have been established for billing services in 15 minute increments, rather than in 60 minute increments. As a result, reimbursement for skilled nursing visits will be at a rate of $15 rather than $60 per visit. Other cost containment strategies are planned for this program in the future.

The Transportation program has witnessed its greatest cost growth in the area of non-medically related transportation for individuals supported by the Frail Elderly (FE) and Physically Disabled (PD) Home and Community-Based Service waivers. Non-medically related transportation costs for these populations comprised approximately one-third of the transportation costs for these populations. A recently implemented restriction ensures that all adult beneficiaries can access only medically related transportation.

Finally, the MediKan program is intended to serve as a bridge program for persons applying for and awaiting determination of federal disability benefits (SSI). An analysis of claims data revealed that some people have received MediKan benefits indefinitely. Because it is reasonable to expect people to complete the application process and qualify for SSI disability within two years SRS has recommended that eligibility be limited to 24 months.

Future Cost Containment Strategies

Medical Policy/Medicaid is currently undertaking a number of initiatives designed to control costs while ensuring that beneficiaries receive appropriate services. Because of the complexity of the program and the need to collaborate with stakeholders (i.e. providers and CMS), these changes will not be implemented quickly. However, they are designed to be structural mechanisms for assisting in the management of the program over time. Below is a description of the initially planned changes.

Pharmacy Management

Preferred formulary: Working with a clinical panel comprised of physicians and pharmacists, SRS plans to develop a preferred drug formulary and to use physician education to gain voluntary compliance with the formulary. This formulary will focus on classes of drugs which have similar clinical indicators. Pricing will be one of the considerations in the placement of a drug on the preferred list.

Prior authorization for persons receiving more than nine prescriptions: Medicaid data indicate that 13 percent of Kansas Medicaid beneficiaries may obtain nine or more prescriptions in a given month. Often these patients are being seen by more than one physician and have multiple health issues. Other states have required that prior authorization be obtained before additional prescriptions can be filled. This will help assure that there is a review of the patient's care and that it is appropriate.

Home Health

An analysis of the growth in home health services indicates that almost half of the costs in this category are for skilled nursing services delivered to persons on the home and community based waivers. These services are being provided in addition to the services provided under the waivers. At least 80 percent of the home health services being provided by nurses do not require the skill level of a licensed nurse. In order to assure that costs are reasonable, individuals on the HCBS waivers will be required to receive prior authorization for home health services to assure that the service meets a criteria of medical necessity.

Developing A Managed System of Care For the Aged & Disabled

Because the aged and disabled populations are generally high utilizers of health care, a more organized system of care could likely both improve care coordination and reduce or contain costs. Medical Policy/ Medicaid staff are beginning to look into how such a system of managed care might be developed, which beneficiaries would best be served by this care system, and which services should be included in this focused effort.

FY 2003 Budget Reductions

The following is a summary of targeted Medicaid eliminations, reductions and Revenue enhancements from the Governor's "Existing Resources" budget. A complete listing can be found in the Governor's recommendations for the 2003 budget.

Description	FY 03 (millions)	
	SGF	AF
Reduce attendant care wages on the PD waiver	(642,000)	(1,600,000)
Require parents to contribute to the cost of providing support through the HCBS waivers or other community based services for their minor children	(1,188,000)	(3,000,000)
Pharmacy changes – decrease pharmacy dispensing fee	(715,540)	(1,797,839)
Pharmacy changes – change prescription ingredient cost calculation	(1,285,148)	(3,229,015)
Pharmacy changes – begin a voluntary, preferred formulary	(398,000)	(1,000,000)
Pharmacy changes – increase co-pay for pharmaceuticals	(1,313,000)	(3,271,000)
Improve administration and management of Home Health services	(4,745,160)	(11,922,513)
Eliminate enhanced transportation for those on PD and FE waivers and non-emergency medical transportation	(479,647)	(1,198,995)
Limit terminally ill patients to services provided through the PD waiver	(527,000)	(1,312,701)
Improve billing practices for therapy services	(130,400)	(327,638)
Substantially reduce payments to Community Mental Health Centers (CMHCs) and psychologists for services to persons living in nursing facilities for mental health.	(514,000)	(514,000)
Reduce Mental Health reimbursement rates provided through MediKan	(3,070,000)	(3,070,000)

Attachment A

Kansas Statutes and Federal Regulations for SRS Medical Programs

Kansas Statutes

K.S.A. Supp. 39-709 - establishes the general eligibility requirements by which applicants could become eligible for medical services.

K.S.A. Supp. 39-708c - provides general authorization for the Secretary to enter into state plans for participation in federal grant programs. The Medicaid State Plan ensures the program is operated in compliance with Federal Regulations.

K.S.A. 39-708c(x) - amended by the 1990 Kansas Legislature, pertains to the establishment of rates for payment of services.

K.S.A. 75-5321a and 75-5945 et. Seq. - transfers long term care programs for the elderly to the Kansas Department on Aging effective July 1, 1997.

K.S.A. 75-7001 et. Seq.- transferred juvenile offender programs to the Juvenile Justice Authority effective July 1, 1997.

K.S.A. 38-2001 et. seq. - directs the Secretary to develop and implement a plan for insurance coverage for Kansas children consistent with 42 U.S.C. 1397aa et.seq: Title XXI of the Social Security Act.

Code of Federal Regulations

42 CFR 431.10 - requires the designation of a single state agency to administer the Title XIX Medicaid Program

42 CFR 440.230 - requires the state plan specify the amount, duration, and scope of each covered service, and that each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

42 CFR 447.15 - requires the state Medicaid plan must provide for participation by providers and must be limited to providers who will accept as payment in full the amount paid by the agency.

42 CFR 447.361 - states that payments under risk contracts for the Title XIX contractors, such as managed care organizations, may not exceed the cost of providing similar services to an equivalent fee-for-service population.

42 CFR 457.606 - outlines the conditions for granting state allotments under Title XXI, and making federal payments for a fiscal year.

42 CFR 457.616 - describes the process for application and tracking of Title XIX allowable payments against the fiscal year allotments.

Independent Living programs are governed by the Federal Rehabilitation Act, Title VII, Sec. 701; 34 CFR 364.2.

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House Health and Human Services Committee
February 25, 2002

Health Care Services

For information contact:
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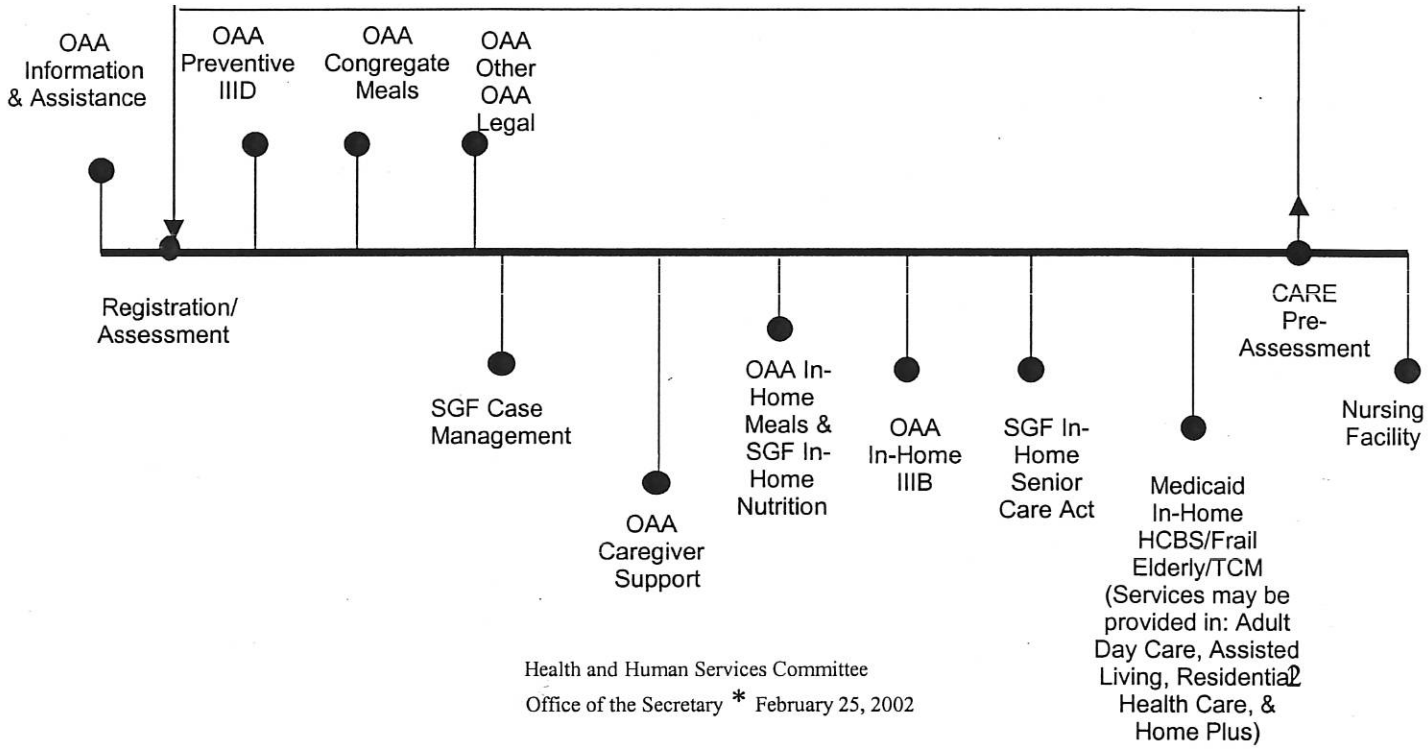
REPORT TO THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE BY SECRETARY CONNIE HUBBELL KANSAS DEPARTMENT ON AGING February 25, 2002

Mr. Chairman, members of the Committee, I am Connie Hubbell, Secretary of the Kansas Department on Aging (KDOA). I appreciate the opportunity to testify before you today in response to your inquiry regarding health care services provided by KDOA and the cost/benefits of those services. KDOA is the primary purchaser, using public funds, of long term care services for the elderly. Health care programs provided by the Kansas Department on Aging are long term care services that support Kansas seniors in maintaining optimum levels of health at the lowest public cost. As such, the programs primarily treat chronic conditions rather than acute care interventions and match the level of need to the level of service as much as possible. The programs are:

- Nursing homes;
- Home and Community Based Services for the Frail Elderly (HCBS/FE);
- Senior Care Act; and
- Nutrition programs.

In cost/benefit terms, the programs should be viewed as a fluid system in that actions taken on one program have consequences affecting other system programs. As an example, the nutrition programs help maintain health status, thus reducing the need for use of the more costly services such as nursing homes. This system is illustrated on the following chart.



NURSING HOME PROGRAM

Statutory Authority

Nursing home services are a joint federal and state partnership that provide a Medicaid service to one of the Title XIX targeted populations, the elderly. Nursing facilities are regulated under Adult Care Home Statutes (K.S.A. 39-923). A nursing facility is defined as any place or facility operating 24 hours a day, seven days a week, caring for six or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who, due to functional impairments, need skilled nursing care to compensate for activities of daily living limitations.

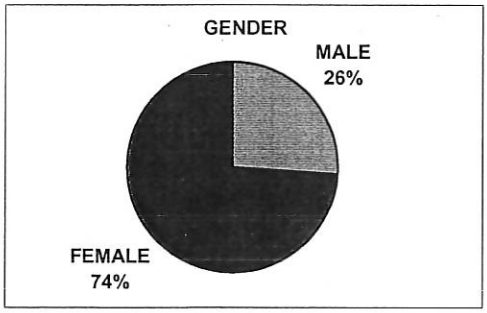
The Kansas Department on Aging (KDOA) administers the Medicaid nursing facility services payment program on behalf of the Kansas Department of Social and Rehabilitation Services (SRS) pursuant to K.S.A. 75-5321a, K.S.A. 75-5945 et seq., and K.S.A. 39-968.

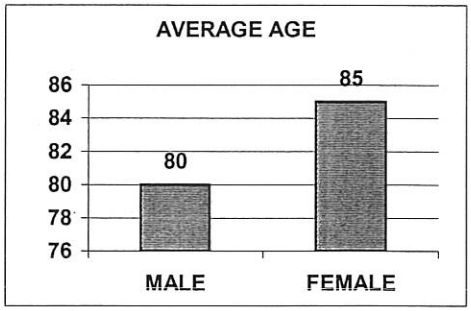
Customer Profile

In order to receive Medicaid nursing home benefits, individuals must qualify both financially and functionally. Financial eligibility is determined by SRS Economic and Employment Support Specialists located in local area SRS offices. Functional eligibility is determined by KDOA based on the Client Assessment, Referral and Evaluation (CARE) process. In order to functionally qualify for nursing home care, individuals must require assistance with such "activities of daily living" as walking, dressing, eating, toileting, and/or bathing, in combination with "instrumental activities of daily living" such as meal preparation, shopping, money management, transportation, and/or medication management. Other risk factors include incontinence, cognition, falls, abuse, neglect, and exploitation. An individual's needs are assessed and "scored" so that appropriate placement is made to ensure a safe environment that meets the individual's needs. The average level of care score for a nursing home resident is 73. Once eligibility is determined, an assessment called the Minimum Data Set (MDS) is conducted by the nursing home staff. The acuity level of each resident is derived from variables on the MDS. The following is a chart with the acuity level of residents as of August 1, 2001.

Customer Acuity Levels As Of August 1, 2001

	RESIDENT CASE MIX		
	EXAMPLES OF PATIENT CHARACTERISTICS	**TOTAL**	**MEDICAID ONLY**
Rehabilitation	Rehabilitation therapy received	7.3%	4.0%
Extensive Services	In past 14 days, received intravenous medication, tracheotomy care, required ventilator/respirator, or in past 7 days received intravenous feeding	0.5%	0.6%
Special Care	Multiple sclerosis, cerebral palsy, quadriplegia, or respiratory therapy	5.2%	5.7%
Clinically Complex	Comatose, have burns, septicemia, pneumonia, internal bleeding, dehydration, dialysis, or receive chemotherapy	27.0%	27.5%
Cognitive Impairment	Alzheimer's disease or other types of dementia	13.7%	13.2%
Behavior Problems	Resist care, combative, physically and/or verbally abusive, wandering, or delusional	1.4%	1.9%
Physical Function	Restricted physical functions	44.9%	47.1%





Customer Demographics As Of August 1, 2001

Age of Residents	08/01/01	Percent
< 25 years old	11	0.1%
25 – 54 years old	473	2.2%
55 – 64 years old	740	3.4%
65 – 74 years old	2,034	9.5%
75 – 84 years old	6,473	30.1%
85 years old and older	11,751	54.7%

Service Providers

As of June 30, 2001, there were 346 Medicaid certified nursing facilities in Kansas, with a total bed capacity of 23,360. These numbers reflect a decrease for the last four years.

Services Provided

Nursing facilities serving Medicaid residents are required to provide the following services:

- Licensed nursing supervision for 24 hours per day, seven days a week;
- Assistance with daily living skills;
- Routine medical equipment and supplies;
- Pharmacy services;
- Dietician services;
- Occupational, physical, respiratory, and speech therapy;
- Specialized rehabilitative services; and
- Transportation.

Many nursing facilities have chosen to provide specialized services such as Alzheimer's units and have broadened their spectrum of services to include assisted living, home health care, adult day care, and respite care.

Purchase of Service Mechanics

Nursing facilities that are licensed by the Kansas Department of Health and Environment (KDHE) and certified to participate in the Medicaid program apply to KDOA to become a provider of Medicaid nursing facility services. Nursing facilities that have been approved as Medicaid providers are reimbursed by KDOA for Medicaid residents. In order to determine allowable costs, nursing homes are required to submit annual financial and statistical reports, which are subject to review by auditors in the KDOA Quality Assurance Commission.

Kansas receives approximately 60 percent federal financial participation for Medicaid nursing home residents, requiring the remaining 40 percent to be funded with state general funds. In order to receive federal funds, nursing facilities must meet federal participation requirements as specified in Part 42 of the Code of Federal Regulations (CFRs). In order to assure that nursing facilities are meeting these requirements, the Center for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration, requires that the state survey agency conduct a standard survey of each nursing facility not later than 15 months after the last day of the previous standard survey. KDHE is the state survey agency and provides survey reports to KDOA, which is responsible for collection of penalties based on findings of substandard quality of care.

Payments/Rates

Nursing facilities are reimbursed for Medicaid resident's care using a cost-based, facility-specific prospective payment system. The average monthly payment for a Medicaid resident in SFY 2001 was $2,184, of which approximately 60 percent are covered by federal funds, with the remainder paid by State General Funds (SGF). According to a Year 2000 analysis by HCIA-Sachs, L.L.C. and Arthur Anderson LLP, the Kansas average payment per resident falls into the fourth, or bottom, quartile of all states.

Total cost of Medicaid nursing home care in Kansas in SFY 2001 was $292,510,306. This includes approximately $175.5 million in federal funds and $117 million in state funds. The average number of residents per month as of June 30, 2001 was 11,162, with an average monthly cost of $2,184 per resident.

Cost/Benefit analysis

The average length of stay (residents who have discharged but have been in a home more than one hundred days) is 2.9 years. The average length of spenddown of personal funds before using Medicaid is 1 year. Medicaid payments, on average, cover two years of nursing home service. The average age of a nursing home resident is 84. KODA is closely monitoring these four variables, length of stay, the spenddown period, years of Medicaid payments, and average age, for future analysis. As community based services continue to develop into viable and available options for seniors, we believe these variables will serve as valuable benchmarks in measuring the activities between nursing homes and community based services.

KDOA regularly monitors the number of Medicaid certified nursing homes, the number of certified beds, and the number of nursing home residents. Since 1998, Kansas has experienced a reduction in the number of nursing homes from 368 to 346 (excluding Nursing Homes for Mental Health). The number of certified beds has also decreased from 25,261 to 23,360. The decrease in the number of nursing home residents, from 11,788 to 11,162, is probably the most significant statistic, however, as it reflects a shift from nursing home services to community based services. Considering the increase in the number of seniors in Kansas, this decrease in the average number of nursing home residents demonstrates the successful development and implementation of community based services which are a desirable choice of many seniors and a cost effective service for Kansas.

HCBS/FE PROGRAM

Statutory Authority

The Home and Community Based Services for the Frail Elderly (HCBS/FE) program provides Medicaid eligible customers with the opportunity to receive cost-effective community based services as an alternative to nursing facility care, to promote independence in the community setting, and to ensure residency in the most integrated setting.

On July 1, 1997, the Kansas Department on Aging (KDOA) assumed management of the HCBS/FE program from the Kansas Department of Social and Rehabilitation Services (SRS). The program operates as a 1915(c) Medicaid waiver, allowing provision of community-based services to persons who are eligible for nursing facility services but have chosen to remain in the community. The federal waiver requires that the average cost of serving these persons in their homes be less than if they had elected to enter nursing facilities.

Customer Profile

The criteria for provision of HCBS/FE services are that the customer shall:

- Be at least 65 years of age;
- Be financially eligible for Medicaid;
- Meet functional eligibility criteria;

The Kansas Department of Social and Rehabilitation Services, the designated single state Medicaid agency, determines Medicaid financial eligibility. Local case managers, who are employed or contracted by AAAs, determine customers' functional eligibility. When a customer elects to participate in the HCBS/FE program, the local targeted case manager develops an individualized plan of care for services which includes:

- Specific services to meet the identified needs;
- The frequency and duration of each service;
- The customers' choice of providers; and
- If applicable, the customers' obligation to pay for part of the service costs.

A customer of the HCBS/FE program is typically a 79 year old woman who needs physical assistance getting in and out of the bathtub, receives home delivered meals, and occasionally needs help with walking since she is unsteady. This customer would need help with both heavy shopping and heavy cleaning. She rarely drives herself to events due to poor eyesight. Her presenting health issues could include arthritis, high blood pressure, congestive heart failure and some incontinence. This customer lives alone in her home. The average Level

of Care score for a customer is 50.

Service Providers

Providers of Targeted Case Management and HCBS/FE services are critical to the success and continuation of the waiver. Through SFY 2001, the average monthly number of HCBS/FE providers has remained stable at approximately 300 unduplicated active providers per month.

Customers with paid services in each Area Agency on Aging are reflected below:

PSA	Area Agency	Customers
1	Wyandotte/Leavenworth	604
2	Central Plains	1,197
3	Northwest Kansas	269
4	Jayhawk	682
5	Southeast Kansas	1,502
6	Southwest Kansas	601
7	East Central Kansas	473
8	North Central/Flint Hills	712
9	Northeast Kansas	393
10	South Central Kansas	873
11	Johnson County	370
Statewide	**Unduplicated Customers**	**7,513**

HCBS/FE Service Providers

Service	Number of Providers
Adult Day Care	25
Sleep Cycle Support	26
Personal Emergency Response Rental	89
Personal Emergency Response Installation	51
Wellness Monitoring	185
Respite Care	11
Attendant Care Services– Level I	201
Attendant Care Services – Level II	304
Assistive Technology	18
Nursing Evaluation Visit	28

Services Provided

The services provided under the waiver are:

- adult day care,

- sleep cycle support,
- installation and rental of personal emergency response equipment,
- wellness monitoring,
- respite care,
- attendant care services level I and II,
- assistive technology, and
- nursing evaluation visit.

Purchase of Service Mechanics

Agencies or facilities interested in becoming a provider for the Home and Community Based Services/Frail Elderly (HCBS/FE) waiver first contact Provider Enrollment within the Office of the Fiscal Agent (currently Blue Cross and Blue Shield) or the Kansas Department on Aging to receive the Kansas Medicaid/Medikan provider application packet. Each packet contains a listing of the service options in which the provider may choose to enroll. The packet also includes phone inquiry listings, explanation of the rules, regulations and policies. Service options are accompanied with enrollment criteria, which allow a potential provider to know what licensure is required for the services(s). It is up to the interested agency/facility to choose which service(s) to enroll in and to submit the proper documentation or required licensure.

The Provider Enrollment unit processes the application. Upon acceptance, the provider number and relevant sections of the Kansas Medical Assistance Program Provider Manual are sent to the provider. HCBS/FE services are reimbursed as a fee for service. Prior authorized services for HCBS/FE customers are provided, documented and then submitted for payment.

Payments/Rates

During State Fiscal Year 2001, a total of $49,585,203 was expended for services that were provided to 7,513 seniors.

The HCBS/FE program uses the fee-for-service method of payment. This method requires the state to establish a uniform payment rate that applies to all providers of a service. Historical data and utilization analysis has been used to establish HCBS/FE rates. The table below outlines the previous and current HCBS/FE rates.

SERVICE NAME	UNIT OF SERVICE	MAXIMUM UNIT RATE EFFECTIVE 1/1/97	MAXIMUM UNIT RATE EFFECTIVE 7/1/00
Adult Day Care	1-4 hours	$13.00	$13.78
Assistive Technology	1 purchase	N/A	$7500 lifetime maximum
Attendant Care- Level 1	1 hour	$12.00	$12.72
Attendant Care- Level 2	1 hour	$13.25	$14.05
Nursing Evaluation Visit	1 face-to-face visit	N/A	$37.10
Personal Emergency Response Service	1 monthly charge	$20.00	$25.00
Personal Emergency Response Installation	1 installation	$50.00	$53.00
Respite Care	1-4 hours	$12.00	$12.72
Sleep Cycle Support	6-12 hours	$20.00	$21.20
Wellness Monitoring	1 face-to-face visit	$35.00	$37.10

On July 1, 2000, all HCBS/FE unit rates for services increased by 6%, with the exception of Personal Emergency Response Service that increased by 25%. Also on July 1, 2000, two new HCBS/FE services were implemented, Assistive Technology and Nursing Evaluation Visit.

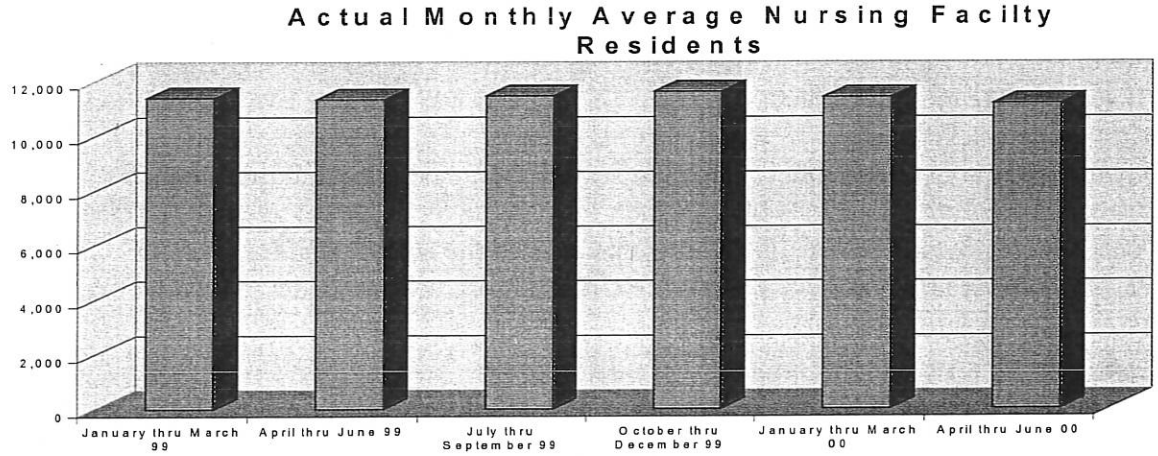
Payments for waiver and other State plan services are made through the Medicaid Management Information System (MMIS), which is operated by the fiscal agent. The current fiscal agent is Blue Cross/Blue Shield. Claims that exceed the amounts authorized for HCBS/FE services are not paid. Payments for HCBS/FE services are made by KDOA to providers.

Cost/Benefit Analysis Related to the 1999 HCBS/FE Waiting List

The 1999 legislature, with the goal of controlling the costs of long term care in Kansas, requested that a waiting list be established for Home and Community Based Services for the Frail Elderly. KDOA implemented the waiting list on July 1, 1999. It was ended on October 18. At that time, there were 367 seniors who had requested HCBS/FE services. By January 24, 2000, the Area Agencies on Aging had reported to KDOA on the disposition of the case files for these customers. This data is shown in the table below.

Number of Customers	Disposition	Percentage
190	Approved plans of care for HCBS/FE services	52%
3	Determined to be functionally ineligible (did not meet NF level of care)	1%
34	Determined to be financially ineligible (did not qualify for Medicaid)	9%
58	Entered a nursing facility and did not transition back to the community	16%
9	Deceased	2%
44	Refused service due to a change in circumstances	12%
13	Received OAA, SCA, or IE services and elected to continue	4%
16	Moved from the region or the case manager was unable to contact them	4%

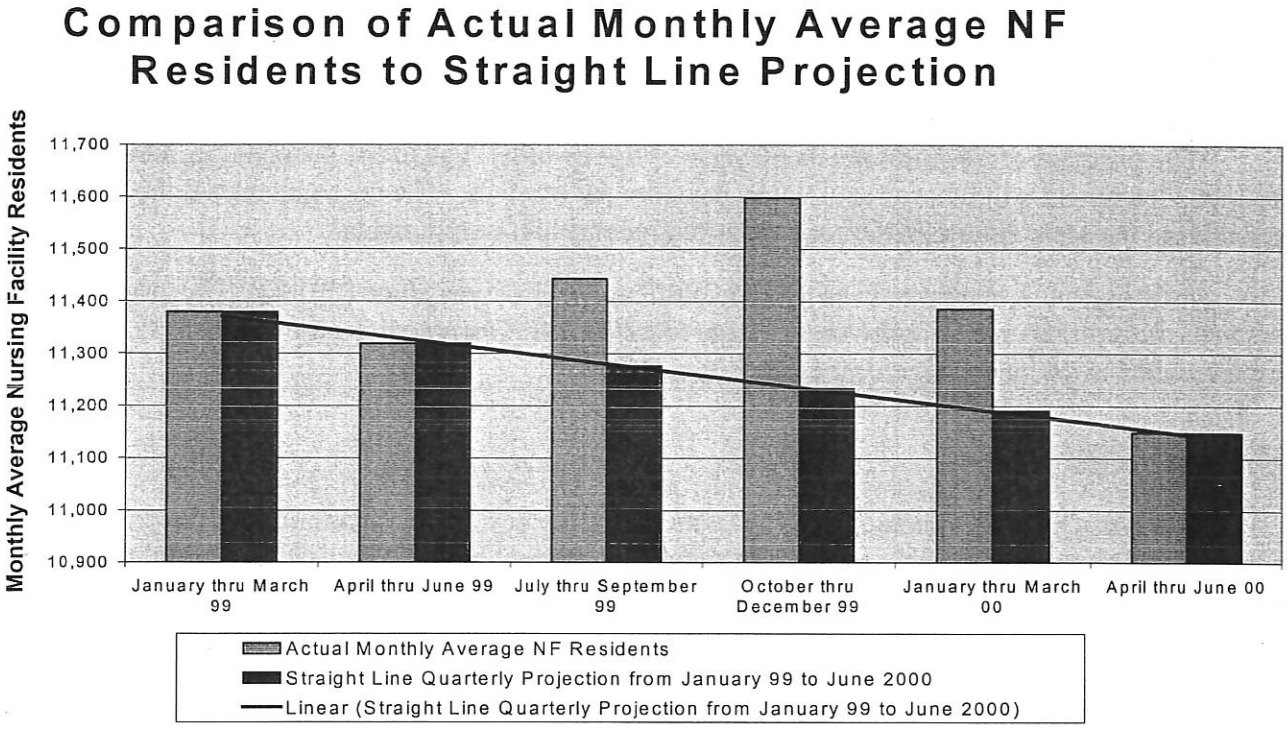
In the last two years, KDOA has analyzed the actual cost/savings of the waiting list option for this population. At first glance, it does not appear that there was a material shift in the nursing facility population during the three-quarters affected by the waiting list. The chart below shows the actual average monthly nursing facility population from January 1999 through July 2000. This time period compares the six months before the waiting list, the six months most affected by the waiting list, and the six months following. (Source: SRS MARS reports. Monthly averages are shown by quarter to smooth out the effect of 4- and 5-week months. Payments are made weekly, and each quarter has one 5-week month.)



However, a closer look indicates that the steady decline in nursing facility population that had occurred since the implementation of the HCBS/FE waiver was reversed during this period. The chart below shows the same time period with an adjusted scale to show the true impact. It also compares actual results to a straight-line projection of the expected decline in nursing facility caseload.

4-11

For July through September 1999 quarter, there were 167 more residents in nursing facilities each month than a straight line projection would have predicted. That number increased to 365 in the following quarter, but decreased to 195 in the quarter after the waiting list ended. The excess cost of caring for these customers in the nursing facility (over what could have been projected, based on declining caseload) was $4.4 million. Using the same analysis for the HCBS/FE program indicates savings of $933,000. **The net cost to the state was approximately $3,467,000 for the nine-month period.**



There is also an on-going difference in cost to the state for the 58 customers on the waiting list that entered a nursing facility and did not choose to re-enter the community. Using the average monthly costs for both programs, and assuming that all of these customers are still in a nursing facility, the difference could be as much as $1,000,000 per year.

SENIOR CARE ACT PROGRAM

Statutory Authority

The Senior Care Act (SCA), (K.S.A. 76-5928, et. seq.) was enacted by the Kansas Legislature in 1989 and implemented in State Fiscal Year 1990. The Act requires development of a coordinated system of services for people 60 years of age and older who face difficulties in self-care and independent living. The program expectation is that it will prevent inappropriate or

premature institutionalization of persons who have not yet exhausted their financial resources.

The 2001 Kansas Legislature directed KDOA to combine all State General Fund programs. In order to accomplish this, during FY 2002 the Agency is combining the Income Eligible, Senior Care Act, Custom Care, SGF Case Management, and Environmental Modification programs into one program entitled the Senior Care Act (SCA).

The combined SCA program provides homemaker, chore, attendant care, and case management services in the customer's home.

Customer Profile

The program serves individuals 60 years of age or older. Under the proposed combined program, customers will have a required co-payment for services. The co-payment will be based on a sliding fee scale determined by self-reported income and liquid assets

A typical SCA customer is an 81 year-old female who lives alone (58.1%). The largest segment of customers are 75 to 84 years of age (42.29%), 40.76 percent are 85 or older, 15.35 percent are 65 to 74, and 1.6 percent are less than 65.

Service Providers

The Area Agencies on Aging (AAAs) are by statute designated to administer the program in their respective planning and service area through a contract with the Kansas Department on Aging (KDOA). They are the Sole Source provider for the funds. The KDOA does not set the unit rate for services.

The AAA's notify potential providers of the application process. Providers submit their bid to provide services based on a contracted unit rate. The AAA's select the providers according to their selection criteria. The selected providers are offered contracts, usually for a minimum of one year to a maximum of three years.

The Area Agencies submit the completed application, including the details of the providers to deliver services, as well as the signed contract to KDOA.

Services Provided

The AAAs determine which services are needed within their planning and service areas. Homemaker services are the most utilized and Attendant Care followed with the next most service units. Other services provided include Respite Care, Chore Services, Medical Transportation, Personal Emergency Response System (PERS), Adult Day Care, and Case Management.

Purchase of Service Mechanics

The AAAs submit claims to KDOA through the KAMIS computer system on a monthly basis. The KDOA issues the payment to the Area Agencies according to each provider's unit rate and the units of service provided for that month.

Payments/Rates

In 2001, the local match contribution and program income for the SCA and Income Eligible programs was $1,308,645. The new combined program is expected to continue receiving this amount from local units of government and customer co-payments. The combined SCA program expended $8,051,936 SGF for services in FY 2001. The FY 2002 budget includes $8,062,974 for the Senior Care Act program. For FY 2003 KDOA estimates 7,302 seniors will need SCA services at an average cost per customer per year of $1,158 if the Governor's restoration package is enacted by the Legislature.

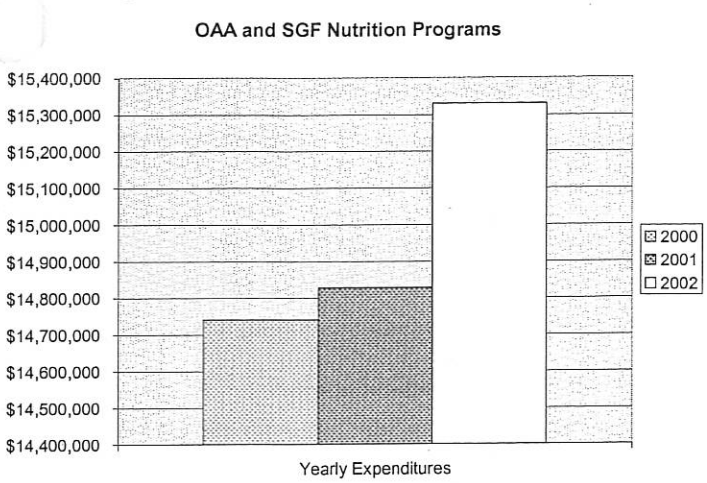
Cost/Benefit Analysis

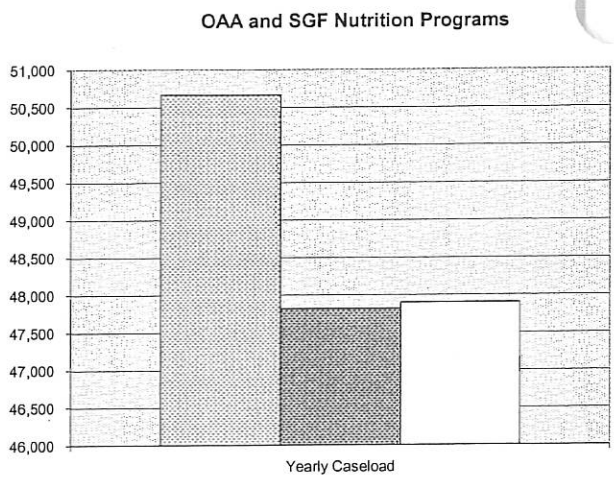
Unlike the HCBS/FE waiver program, SCA customers are not required to meet nursing home eligibility to receive services. Therefore, we acknowledge that not all SCA customers would chose nursing home care as an option, nor would they be eligible. However, if only 5% of the projected 7,302 projected SCA customers for FY 2003 were to enter nursing home as Medicaid customers, the cost to the State on average would be $4.3 million a year SGF (NF $975.60 x 365 x 12) compared to $422,670 SGF ($1158 x 365) for SCA services to these customers.

NUTRITION PROGRAM

Statutory Authority

The Kansas Department on Aging funds a congregate meal program that, according to AAA Area Plans, provides meals at 317 sites in communities throughout the state. The program also provides nutrition education, nutrition transportation, and outreach services to qualifying seniors and their spouses. KDOA also funds home-delivered meals to homebound individuals. These meals are provided through the Older Americans Act (OAA) Home-Delivered Meals Program and the State Funded In-Home Nutrition Program.





Title III-C of the Older Americans Act of 1965, as amended, authorizes nutrition services for persons age 60 or over and their spouses and, in certain conditions, persons with disabilities under the age of 60. Meals are provided to eligible participants on a contribution basis in a congregate setting (Title III-C(1)), or within a homebound individual's place of residence (Title III-C(2)).

Customer Profile

Characteristics of persons receiving meals were as shown in the following table:

Characteristics	Congregate	Home Delivered
Male	44%	31%
Female	56%	69%
Lives Alone	47%	54%
Aged 64 and under	12%	6%
Aged 65 to 74	31%	22%
Aged 75 to 84	39%	41%
Aged 85 or older	18%	31%

Service Providers

The Area Agencies on Aging submit the list of providers and their respective service costs to their governing boards for acceptance and approval. This information is subsequently submitted to KDOA in an annual area plan document. KDOA issues notification of grant awards based on these plans.

Services Provided

Meals served by PSA during FFY 2001 under Title III of the Older Americans Act were as follows:

AAA	Congregate	Home Delivered	Total Meals
Wyandotte/Leavenworth	89,502	188,078	277,580
Central Plains	193,957	248,796	442,753
Northwest Kansas	175,317	61,406	236,723
Jayhawk	116,064	86,087	202,151
Southeast Kansas	117,645	181,166	298,811
Southwest Kansas	266,355	100,932	367,287
East Central Kansas	115,467	87,808	203,275
North Central/Flint Hills	246,777	141,489	388,266
Northeast Kansas	100,373	65,903	166,276
South Central Kansas	205,734	115,588	321,322
Johnson County	42,712	137,637	180,349
Statewide Total	1,669,903	1,414,890	3,084,793

Purchase of Service Mechanics

OAA funds are awarded to 11 Area Agencies on Aging through an intrastate funding formula. Seven area agencies contract or grant the funds to local providers through a RFP process. Four area agencies provide the service directly under a waiver from the Secretary of Aging.

Payments/Rates

Title III-C1 congregate nutrition expenditures were $2,952,766 (federal funds) and 1,669,903 meals were provided to eligible participants. The Home Delivered meals program provided 1,414,890 meals at a cost of $1,612,696 (federal funds).

Payment processes with service providers are outlined by the AAAs in their respective sub-grants or contracts. For services provided under a waiver, the area agency submits a cash request to KDOA. The cash requests submitted to KDOA reflect cash advances for the following month based on estimated expenditures. KDOA electronically transfers the funds, a process that takes a maximum of eight days from the time Fiscal Services initially receives the cash request.

Cost/Benefit Analysis

An important component of any long-term care system is the provision of adequate nutrition services to ensure that optimal nutritional status in the older population is achieved and maintained. In Kansas, the nutrition programs are closely linked with the home and community based programs. As hospitals and nursing homes discharge the elderly more quickly into the

community, these services are available to assist the individual with meeting their nutritional needs to avoid further institutionalization.

In the 2000 Survey of Kansas Seniors, respondents were asked to identify the concerns of most significance to them. The cost of food and maintaining a healthy diet ranked third and fourth, respectively. In a most recent evaluation conducted by the Administration on Aging of the OAA Title III-C programs, the following were key findings:

-Individuals participating in the meal program have higher daily intakes of key nutrients than similar nonparticipants.

-The meals provide approximately 40 to 50 percent of participants' daily intakes of most nutrients.

-Participants have more social contacts per month than similar nonparticipants.

The results indicate the OAA III-C programs are successful in accomplishing the mission of improving the nutritional intakes of the elderly, as well as decreasing their social isolation. In Kansas, the programs operate very cost effectively as the federal and state dollars are highly leveraged. Despite the participant's low income levels, their contributions account for approximately 32 percent of both the congregate and home-delivered meal costs. In addition, volunteer time is significant to the success of the programs.

Mr. Chairman and members of the Committee, thank you for the opportunity to respond to your questions regarding health care services provided by the Department on Aging. I will now stand for questions.

KANSAS BOARD OF
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Governor

M E M O R A N D U M

DATE: February 25 , 2002

TO: Rep. Garry Boston, Chair and Members
House Health and Human Services Committee

FROM: David Lake, Director
State Board of Emergency Medical Services

RE: Testimony in support of HB2912

Mr. Chairman and members of the committee, Thank You for the opportunity to provide testimony in support of HB2912. This proposed legislation requests that you consider two issues.

The first issue is one of adding the term and definition for a "paramedic" to K.S.A.65-6112. At the present time, Kansas is one of only two states that identifies its most advanced level of trained emergency medical technician provider as a Mobile Intensive Care Technician or MICT for short. This level of training is identified nationally as "paramedic" in the National Standard Curriculum which we have adopted and by the National Registry of Emergency Medical Technicians which we utilize for testing and initial certification.

Many Kansas providers have made it clear they are very proud of the current identification and wish to maintain the "uniqueness" of the identity as a Mobile Intensive Care Technician. However, the uniqueness of the term has occasionally created an insurance reimbursement problem for some services as they require documentation of care provided

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by the more commonly accepted identification of "paramedic" for the increased payment allowable for advanced level patient care.

In response, the Board proposes adding the term paramedic to our definitions to mean a person who holds a mobile intensive care technician certificate or a paramedic certificate issued by the Board. This approach has been met with acceptance by those wishing to maintain their identity.

The second issue being addressed by HB2912 is one of allowing the Board of EMS to identify authorized activities for an EMT, EMT-Intermediate, and EMT-Defibrillator through rules and regulations. At present, State Statutes identify five levels of EMS certification; First Responder, EMT, EMT-Intermediate, EMT-Defibrillator, and Mobile Intensive Care Technician. This proposal does not effect the First Responder level or the MICT level, it establishes parity for the EMT, EMT-I, and EMT-D with regard to the Board's authority to determine those activities it considers to be appropriate for attendants at those levels to be providing to victims of sudden illness and injury.

K.S.A. 65-6144 states "A first responder may perform any of the following activities: (a) through (l) and (j) "other techniques of preliminary care a first responder is trained to provide as approved by the board".

Pre-Hospital Emergency Medical Services is a rapidly growing profession. Organized EMS in Kansas is barely thirty years old. Training curricula, diagnostic equipment, and treatment modalities are continually changing and improving to address the goal of EMS which is to reduce morbidity and mortality from sudden illness and injury. To provide the best possible care to our citizens the board must be able to respond to these changes in a timely manner and with the best interest of that public in mind. I believe this capability with appropriate safe-guards have been considered and are built into the proposed legislation.

The proposed language for addition to each of the three levels of certification states, "the board may adopt rules and regulations authorizing other techniques of patient care that an attendant at the specified level of certification may provide after

considering: 1)The training curriculum of an attendant at the level involved; 2) any limitation prescribed by national organizations in the EMS professions which address the attendant; and, 3) services recognized by the EMS profession as appropriate to be performed by an attendant at the level being considered."

Additionally, to perform any of the authorized activities requires medical protocols approved by the ambulance service's medical director (a physician) and the local component medical society. If local medical control does not want EMS Personnel performing any of the current authorized activities or any that may be included in the future, they simply do not approve a protocol authorizing the activity.

This request is not "breaking new ground" as may be suggested by opponents. K.S.A. 65-1130 states, (c)"the board shall adopt rules and regulations applicable to advanced registered nurse practitioners which 1)establish categories of ARNP's which are consistent with nursing practice specialties recognized by the nursing profession. 2)establish education and qualifications necessary for certification for each category of ARNP. "In defining such role the board shall consider:

K.S.A. 65-1136 states, "the board may adopt rules and regulations: 1)which define the limited and expanded scope of practice of intravenous fluid therapy which may be performed by a licensed practical nurse.

I would like to give you a couple of examples of additional authorized activities that the board has been asked to consider with regard to treatment of emergency patients. In the last few years, the American Heart Association has promoted an initial step in treating a heart attack as taking an aspirin. They encourage this to be done only after contacting EMS. Administering an aspirin, if appropriate, is not an authorized activity for an EMT. While I may encourage a patient to take an aspirin after considering any indications and contra-indications, we may not be in a locale where an aspirin is available. Taking the aspirin could have a very positive effect on the outcome of the patient.

A year ago, a physician from Western Kansas contacted

me and wanted to know why EMT's cannot carry and utilize an "epi-pen". A young patient had experienced an allergic reaction and while the EMT's made a valiant effort to treat and resuscitate the patient, the physician felt like the use of an epi-pen may have very likely saved the patient. Nationally, the Food Allergy Network is encouraging the training and use of an epi-pen by emergency responders.

In closing, when considering this proposed legislation I ask that you keep in mind the Board of EMS is a professional, regulatory board comprised of Physicians, Legislators, EMS Service Directors, EMS Providers of all levels, County Commissioners, and at present an Advanced Registered Nurse Practitioner while that is not a criteria for appointment. This professional makeup is qualified, capable of, and charged with making decisions that direct emergency medical services in Kansas. Their primary mission is to protect the public. I believe this proposed legislation enhances their ability to fulfill their mission.

Thank You for the opportunity to present this testimony and I will be happy to respond to any questions, comments, or concerns you may have.

Members of the Committee on Health and Human Services:

My name is Bob Orth. I am the President of the Kansas Emergency Medical Technicians Association, Vice-President of Region 2 Emergency Medical Services of Southwest Kansas, Director of the Sublette Ambulance Service, an EMT-I/D, an Instructor-Coordinator and a state and regional examiner. I have been involved with out-of-hospital care for 26 years.

What I am allowed to do and the care I am allowed to deliver is set by Kansas statute. As you are well aware, the legislative process can only happen once a year. A suggestion was made several years ago that the Board of Emergency Medical Services should not come to the legislature every year with changes to the laws that govern emergency medical services in Kansas.

In HB 2912, the Board of EMS is asking for a more responsive way to update the care I am able to give and the people that function in your local ambulance service can give.

Television tells us that an aspirin may help if a patient is experiencing chest pain. I can't administer aspirin nor am I allowed to carry aspirin in the ambulance because it is not a part of my allowed activities as set by statute. A pulse oximeter is a device that measures the saturation level of oxygen by sensing the color of blood as it circulates through the body. It can give an indication of whether the ventilatory treatment I am giving a patient is working. Not in my allowed activities. As an EMT-I, I can do glucose checks by pricking a finger and reading the drop of blood with a glucometer. The EMTs on my service can not.

These are only three examples of things that would allow my ambulance service to better serve it's constituency and allow your local ambulance service to serve your fellow citizens more completely.

The permission that the Board of EMS is asking you to statutorily approve has built-in limits. The Board can adopt rules and regulations only if a suggested change in patient care is contained in a nationally recognized curriculum, it recognizes any limitations that are prescribed by national organizations and the emergency medical services profession recognizes that the services are appropriate for that level of attendant.

The legislature maintains oversight of each rule and regulation that the Board of EMS requests. Additionally, hearings are held for interested parties to voice their thoughts concerning any rule and regulation the Board prepares for approval.

The Board of Emergency Medical Services has many professionals in out-of-hospital care, both Board members and staff. The care I can deliver and the care your neighbors can receive deserves to be as current as possible. Please allow those professionals the ability to set that care through the process they are requesting.

Thank you for allowing me to testify and I would be happy to answer any questions you might have.

H&HHS
2-25-02
Atch #6

Kansas EMS Association (KEMSA) comments on HB 2912
February 25, 2002 by Jason White, Vice President, KEMSA

KEMSA is a professional association that represents EMT's, paramedics and the ambulance services around Kansas that provide critical services to the residents and guests of our state.

KEMSA supports the passage of HB 2912

The debate around this bill centers on the issue of "authorized acts".

The debate is about whether changes in "authorized acts" should remain the exclusive prerogative of the state legislature or whether to change the law to allow some discretion to the Board of EMS.

The provision of emergency health services via the technicians with ambulance services is regulated at several levels that are much more successful than the current reliance on the legislative process.

Presently if we are to allow basic EMT's to perform simple Dextrose sticks, which are performed by diabetics millions of times a day throughout the country, we must change the state law.

The proposed change would allow the following process to function.

Procedures provided at the local level are regulated by the local medical society or a committee of the local hospital. This process is defined in current law. This means that procedures done by EMT's or paramedics are already closely monitored by the physicians that work in that community. This oversight is not advisory....it is regulatory.

The Board of EMS has four legislators as formal members. The Board tends to be conservative in its approach and the membership is based on the nomination and approval process from the legislature. KEMSA is comfortable that the "authorized acts" that may be included through regulation will not infringe in the practice of medicine in any way but instead will be controlled by the medical community.

The process of creating a regulation is long and terminates with a committee of legislators.

KEMSA feels that the proposed process to allow for the limited expansion of the "authorized acts" provides more than enough safeguards to protect the public. In fact some of us believe that the process remains to long and cumbersome meaning that the provision of emergency health services provided in Kansas will not be on the cutting edge but instead well behind the wave.

KEMSA supports the passage of HB 2912.

HsHHS
2-25-02
Atch# 7

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TO: House Committee on Health and Human Services

FROM: Chris Collins
Director of Government Affairs

DATE: February 25, 2002

RE: HB 2912: Emergency Medical Services

Ladies and Gentlemen of the Committee:

Thank you for the opportunity to voice the Kansas Medical Society's opposition to HB 2912.

The Kansas Medical Society has historically supported the activities of the EMS Board and understands and appreciates the critical role that emergency medical service providers play in the delivery of emergency health care. The relationship of physicians and emergency medical services providers has been a long-standing one of mutual support and respect.

Because of that relationship, KMS stands in opposition to the bill before you today with some reluctance. KMS remains supportive of the EMS Board's goal to update its act. Nonetheless, passage of HB 2912 would represent a material deviation from the law governing almost all other health care professionals. This bill would permit the Board of EMS to determine its own scope of practice by rule and regulation. From a legal standpoint, this is potentially problematic. It is unconstitutional for the legislature to delegate its rule-making authority to a state agency. From a practical standpoint, it eliminates meaningful public scrutiny and input from other health care professionals when the state agency, comprised of a majority of EMT's, determines what authority EMT's may have. Almost all other acts governing health care professionals contain a statutory scope of practice that is subject to scrutiny and discussion by other health care professional groups. This seems fair and by and large has served Kansas health care professionals well.

Moreover, this centralization of decision-making authority has the potential to alter a long standing practice of collaboration between local hospitals, medical societies and local EMS providers in determining EMT protocols. This has been an effective means of ensuring flexibility and autonomy on the local level. This has been a valuable practice because more extensively trained service providers could safely undertake a higher level of responsibility. In contrast, services comprised

solely of community volunteers could still provide a critical service to their neighbors but with a little more oversight by medically trained professionals. We are concerned that the centralization of these standards and protocols may eliminate the necessary flexibility that has served the state of Kansas and its diverse rural and urban populations well.

For the foregoing reasons, KMS supports the concept of updating laws related to EMS but respectfully urges this committee to not recommend the bill before you today for passage. Thank you for the opportunity to testify today. I am happy to answer any questions.

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February 25, 2002

H.B. 2912 EMS Services; *Paramedic Definition added and Rule/Regulation authority sought to add to existing task list*

Written Testimony

Chairperson Boston and members of the House Health and Human Services, the KANSAS STATE NURSES ASSOCIATION has been studying the proposals by the Board of EMS regarding changes to the scope of practice for EMS personnel and the processes used to add/delete techniques that may be performed by this category of unlicensed personnel. We have several comments regarding H.B. 2912 for your consideration.

DEFINITION OF PARAMEDIC ADDED

H.B. 2912 adds a definition of "paramedic" (on page 2 line 31, new (s)) and this definition is consistent with the common terminology used by health care providers and used within literature by the National Highway Traffic Safety Administration related to emergency services personnel. KSNA supports the addition of this terminology to the EMS list of definitions and use throughout their act.

REQUEST FOR RULE AND REGULATION AUTHORITY

The remainder of the bill appears to include new language which would authorize the Board of EMS to by rule and regulations add tasks that the unlicensed emergency personnel could perform in Kansas. Currently, the list of techniques that can be performed by each category of emergency personnel are in the statute. This proposal would eliminate the review by the legislature of additions to the list of functions/techniques that can be performed and give the Board of EMS the authority to add to the list using the criteria listed on page 3, lines 33-43. This specific request for rule and regulation authority by the Board of EMS appears to be outside the practices that have been used in the past to authorize additional life-saving/monitoring techniques for use by EMS personnel. At this time, we cannot support the mechanics of the request to move it outside the legislative arena. The techniques that are going to be performed are done by unlicensed individuals, with a civil tort standard of "gross negligence" and we support that any additions to the list of services/techniques to be added should be considered and approved by the legislature. There appears to be no compelling reason to change the mechanism for review and revision to a less stringent process. The publics interest may not be as well served by such a change.

We appreciate your consideration of these comments as you consider this proposed legislation.

Hs HHS
2-25-02
Atch # 9