Approved: 3-1-07
Date

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

The meeting was called to order by Chairman Brenda Landwehr at 1:30 P.M. on January 25, 2007 in Room 526-S of the Capitol.

All members were present except:
Sue Storm- excused
Tom Holland- excused

Committee staff present:
Norman Furse, Revisor's Office
Melissa Calderwood, Legislative Research
Mary Galligan, Legislative Research
Patti Magathan, Committee Assistant

Conferees appearing before the committee:
Ron Gaches on behalf of Kansas Occupational Therapists Association
Federal Department of Health and Human Services representatives:
Fred Schuster
John Babb
Jackie Glaze
Robert Epps
Robert Florance
Gary Allen
Nancy Thoma Groetken

Others Attending:
See Attached List.

Chair Landwehr opened the floor for bill introductions.

Mr. Ron Gaches, representing the Kansas Occupational Therapists Association, requested a bill regarding direct access to occupational therapists. The current law provides direct access in an educational setting. They would like to modify current law to allow direct access for all non-medical settings. Motion to introduce the bill made by Representative Rhoades and seconded by Representative Hill. Motion carried.

Representative Patton motioned that three bills be introduced. The first concerns health insurance related to the assignment of insurance payments for covered services. The second requests health care price transparency. The third describes disclosure and availability of quality and performance indicators by certain health care providers. Motion seconded by Representative Kiegerl. Motion passed.

Chair Landwehr then opened the floor to **Fred Schuster** from Federal Health and Human Services.

Mr. Schuster stated that the priorities of his department are value-driven health care, and health care transparency. (Attachment 1) He discussed the four cornerstones defined by the federal government for health care providers. They are quality standards, price standards, interoperable health system, and properly placed incentives. The Federal Government is in the process of getting state governments and private businesses to sign-on to the four cornerstones. He then asked that the State of Kansas consider adopting these cornerstones with businesses providing health care in our state.

Next presenter was **Robert Epps** from the Center for Medicare/Medicaid Services who discussed the types of Medicare payments and changes to Medicare part B premiums beginning in 2007. (Attachment 2) Projections call for the entire federal budget to be consumed by health care costs by the year 2050. It is clear that the path we are on is not sustainable. Transparency and preventive services are important steps to turn around the growth of health care costs.

Jackie Glaze Program Services Branch Manager in Division of Medicaid and Children's Health discussed Medicaid issues. She provided an update on grants which Kansas is receiving from medicaid services. Kansas is the first state to receive benefits under the SBA program, which deals with working disabled. We

also are one of ten states awarded a grant dealing with home and community based alternatives for children and mental health residential treatment facilities. Kansas also received a grant, announced today, to improve economy, efficiency and care within the Medicaid program.

John Babb, Region 7 Health Administrator and an Officer in the United States Public Health Service Commission Corps, discussed several health programs administered by his office, including Title 10 funding for family planning clinics.

Mr. Babb also provided some miscellaneous statistics. Studies have pointed out that up to 40% of people do not understand the directions on their prescriptions, or have poor health literacy. He also pointed out that of the medically under-served population, many are minorities. He said that the methamphetamine crisis is particularly acute among Native Americans. Also, 58% of Americans are overweight, 7% have diabetes, and another 3% don't even know they have diabetes. This is the first time that it is likely that this generation has a lower life expectancy than their parents.

Nancy Toma Groetken, Child Support Program Specialist with Federal Office of Child Support Enforcement-Administration of Children and Family. (Attachments 3 and 4) This program serves more children and than other federal program. Ninety percent of the money received is passed on to the families. Next to mother salaries, child support is the second largest source of income for poor families. Changes currently going on in the program are due to the Deficit Reduction Act. One change is that they will no longer match federal money with federal money.

Robert Florence, Program Specialist with Administration on Aging discussed data from a 2004 study. (Attachment 5) He also laid out a strategic plan of five priorities: the plan is for older Americans, goal to help elders stay active and healthy, support families to provide care in the home, ensure rights and prevent abuse, and to promote effective responsible training. Strategies to achieve the mission include advocacy, consumer and public education, grants, technical assistance, demonstrations and model programs, and partnerships. Meeting was adjourned at 2:45. Next meeting will be January 30th at 1:30 P.M.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

HOUSE HEALTH AND HUMAN SERVICES
COMMITTEE GUEST LIST

DATE: JANUARY 25, 2007

NAME	REPRESENTING
Ron Gaches	KOTA
Robert Florance	Admin on Aging / HHS
Gary Allen	ACF / HHS
Scott Weinberg	ACF / HHS
Robert Epps	CMS / HHS
Jackie Glaze	CMS / HHS
Nancy Groetken	ACF / HHS
John Babb	RHA / HHS
Fred Schuster	HHS
Mike Hammond	ACMHCK
Michelle Ponce	SRS
Jarrod Forbes	United Healthcare
GARY BRUNK	KANSAS ACTION CHILDREN
Karl Wenger	Kearney & Associates
Sue Faust	KDHE

Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, SW
Washington, DC 20201

Better Care, Lower Costs

You deserve to know... Health Care Transparency

Michael O. Leavitt

Secretary
Health and Human Services

House Health and Human Services
DATE: 1-25-07
ATTACHMENT 1-1

Vision

Every American should have access to a full range of information about the quality and cost of their health care options.

Americans are value-conscious consumers. We clip coupons, check for bargain flights on the Web, and carefully research our next car purchase. It's the American way.

Yet when it comes to almost any aspect of health care, we lack the tools to compare either quality or cost. Consumers need to know – and they deserve to know – the value of their health care.

I believe that bringing transparency to quality and cost information will reform health care in America.

Providing reliable cost and quality information empowers consumer choice. Consumer choice creates incentives at all levels, and motivates the entire system to provide better care for less money. Improvements will come as providers can see how their practice compares to others.

As value in health care becomes transparent, everything improves: costs stabilize; more people are insured; they get better health care; and economic competitiveness is preserved.

Achieving transparency will require commitment and collaboration on the part of everyone in our health care system.

This change is within our grasp. I have talked with key players at all levels across the country, and I believe that the will to change is there, and the time to act is now.

Michael O. Leavitt, Secretary
Department of Health and Human Services

1-2

"To keep this country competitive, we've got to have a health care system that provides our people with good quality health care at affordable prices."

– President George W. Bush
Address
American Hospital Association
May 1, 2006

An Agenda for Change

Exponential change often starts with a single small step.

It's difficult to imagine life today without the World Wide Web. This powerful and ubiquitous tool, with millions of Web sites and countless pages, started with the posting of a single document just 15 years ago, August 6, 1991, to be exact.

The genius of the Web is that the free flow of information – transparency – is interoperable – available to all. Working together, we need to apply that same genius to reshaping America's health care system:

- Implement the Presidential Executive Order
- Establish AQA and HQA as national arbitrators of quality care standards
- Develop standards that define episodes of care for frequent procedures and conditions
- Build a network of Quality and Price Information Collaboratives (QPICs) across many communities to:
  - Cross-pollinate ideas and best practices
  - Harmonize and make interoperable price and quality standards
- Engage quality improvement organizations in the developing and nurturing of QPICs.
- Attract support of large employers, unions, and states
- Develop a private sector business model for the American Health Information Community
- Accelerate the creation and adoption of health IT standards, with emphasis on standards for collection of data measuring AQA/HQA quality standards
- Expand adoption of health IT among small to medium care providers
- Develop standards that enable the gathering of quality and price information from private sector and government health care programs
- Create protocols to aggregate price and quality information at the regional and local levels with the involvement of the QPICs — make this information available in an easy-to-use format.
- Provide education and incentives that will stimulate adoption and drive change
- Develop pay-for-performance incentives

I am confident that, with public policy adjustments, the wise application of technology, and the productive will of many, we shall forge a viable health care system for the 21st century.

Visit the HHS transparency Web site at:
www.hhs.gov/transparency.

Health Care in Crisis

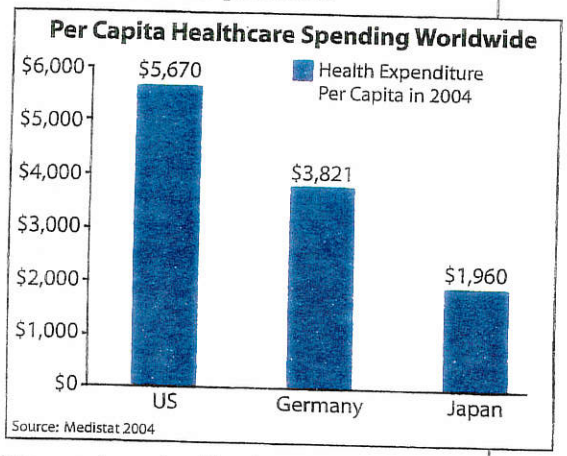
America faces a health care crisis.

America's per capita health spending is the highest in the world. Our spending is nearly one and one-half times that of Germany, and nearly three times more than Japan.

These costs are putting our nation's economic vitality at risk. Health care consumes over 16 percent of our gross domestic product, and that figure could surpass 20 percent within a decade. Companies like GM report spending more on health care than steel in their cars. Starbucks reported that, in one year, they spent more on health care than on materials for brewing coffee.

There is simply no place on the economic leader board for a nation that spends a fifth of its gross domestic product on health care.

Families are also feeling the bite. Health care costs are growing three times faster than wages. Teachers in my home state received the largest salary increase in years but many of them still saw a reduction in their take-home pay because of higher health insurance costs.



Increasing numbers of employers and people alike simply can't afford health insurance. More people than ever – 45 million at latest count – are without health care insurance.

Yet despite outspending the world, patient surveys rank the U.S. behind many developed nations in the quality of health care. We can do better. We must do better.

In a global economy, we either get control of this, or we get beaten.

Four Cornerstones

Everyone talks about transforming America's health care system.

But in fact, the term "health care system" is a misnomer. And that's part of the problem.

Health care is provided by a disconnected collection of large and small medical businesses, health care professionals, treatment centers, hospitals, and all who provide support for them. Each player may have its own internal structure for gathering and sharing information, but nothing ties those isolated structures into an interoperable national system capable of making information easily shared and compared.

> ***"I ... applied everywhere for information, but in scarcely an instance have I been able to obtain hospital records fit for any purposes of comparison."***
>
> **Florence Nightingale**
> Notes on Hospitals, 1863

Interoperable systems are invisible but essential. We have come to depend on many. When you use a cell phone to talk with a friend who uses a different cell service, you are using an interoperable system. Your ATM card is good not only at virtually all banks nationwide, but thanks to a secure interoperable system, you can use it to buy everything from groceries to gasoline.

These systems work because the telephone and banking sectors have developed methods and standards that allow participants in their systems to easily access and exchange information while the companies operate independently and compete vigorously.

Cell phone providers are keenly aware of their competitor's quality of service. Banks closely monitor competitive rates. Customers are able to compare both quality and cost. Value-based consumer choice, in turn, drives greater competition and increasingly better service.

I've met with the CEOs and human resource leadership of many of the Fortune 100 companies. They tell me they are ready to burst into flames over ever-increasing health care costs.

It is not just CEOs who are concerned. Andy Stern, head of the Service Employees International Union, wrote in a *Wall Street Journal* article, "McKinsey & Company projects that by 2008, the average Fortune 500 company will spend as much on health care as they make in profit. How can we possibly compete in the global economy with that kind of burden?" Stern is concerned because he sees health care benefits disappearing and worries that jobs may follow.

Companies and unions alike have a vested interest in the success of transparency-driven health care reform.

States, too, have key roles to play. Both as employers and as operators of state Medicaid programs, governors can bring a significant segment of health care business to the marketplace.

It is clear that change is coming. The pieces necessary for change are falling into place. We have a unique opportunity – all of us, everyone concerned – to fuel this change process.

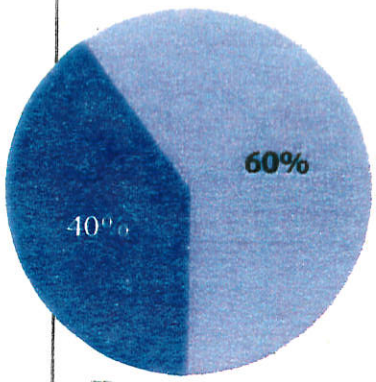
> ***"In 2005, General Motors spent $5.3 billion for health care. That's more than we spent on steel."***
>
> **Rick Wagoner, CEO of General Motors**
> Testimony before the Special Committee on Aging, United States Senate, July 2006

The time to act is now.

Igniting Change

Change of this scale requires critical mass.

Federal health care programs can provide that mass. Together, the Departments of Defense, Health and Human Services, and Veterans Affairs and the Office of Personnel Management are the biggest purchaser of health care in the world. Federal programs cover some 93 million people, nearly 40 percent of the nation's insured.



We are using this critical mass to begin moving the marketplace. On August 22, 2006, President Bush issued an Executive Order, *Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs*, to ensure all federal agencies and those who do health care business with the government incorporate the cornerstones of health care transparency, requiring:

- Aggregated health care quality and price information be available to beneficiaries, enrollees, and providers in a readily usable manner.
- Interoperable health IT products be used, and quality and price data be aggregated and shared.
- Federal participants are motivated to become involved consumers with the power of choice and a reason to advocate a value-based health care system.

The application of health IT and the aggregation of price and quality data on this magnitude jump start the establishment of the nation's electronic health care network.

With nascent technology standards in place, and with local pilots a test bed for quality and price standards, we have the fuel for igniting change.

# of Value-Based Health Care

America's health care system is embracing transparency; by doing so, it is creating a powerful force for change. Transparency is being built on four cornerstones:

- **Quality Standards:** Systems need to be designed to collect quality-of-care information, and doctors and hospitals must help define what constitutes quality care.
- **Price Standards:** Agreement is needed on how to aggregate claims information so "episode of care" costs for specific doctors and hospitals can be measured and compared.
- **Interoperable Health System:** Standards must be set so different health information systems can quickly and securely communicate and exchange data.
- **Properly Placed Incentives:** All parties – providers, patients, insurance plans, and payers – must be subject to contractual arrangements that reward both those who offer and those who purchase high-quality, competitively-priced health care.

The architecture of a reformed health care system is being drafted — each of us has a role in completing the design and building the structure.

quality + price = value

1-5

Quality Standards

Health care is like any other service: some providers are better than others.

Quality of care is of critical interest to patients; their health, even their lives, can be at stake. They need and deserve to know. Doctors want to know too.

> ***"Thirty-four percent reported getting the wrong medication or dose, incorrect test results, a mistake in their treatment or care, or being notified late about abnormal test results."***
>
> **Commonwealth Fund Survey**
> November 2005

What constitutes good quality? Let's acknowledge that the measurement of health care quality is full of complexities. As a medical discipline, it is still in the pioneering phase.

But it can be done; and some professional health groups are already doing it. Measuring quality requires accepted definitions and standards. Gathering data on quality requires electronic records and the ability to share aggregated health data.

Standards should not be dictated; they need to result from broad health care collaboration across private and public sectors. The Department of Health and Human Services (HHS) helped convene two such private-public collaborations, the AQA (formerly the Ambulatory Quality Care Alliance) and the Hospital Quality Alliance (HQA), to identify quality measures for standard ambulatory and hospital care episodes.

Already, the AQA has created a "starter kit" of quality measures for 26 common conditions or procedures. Under a planned Medicare initiative in six pilot cities — Boston, Indianapolis, Minneapolis, Madison, San Francisco, and Phoenix — community collaborations will apply and expand these measures. We will help other communities do the same.

Many physicians have said to me, "I go to work every day, and I do the very best I can to help and heal people. I have no idea how I compare with the larger universe of physicians. I would love to know how my results compare – I can learn from that."

The fact is, we all can.

A System of Incentives

Incentives motivate and competition works.

A car company offers no-interest loans to motivate buyers. Others quickly follow suit. You select one make over another because it offers more options for the same price.

Incentives drive action and change. You are given a reason to care about making a good choice, and the marketplace is changed as others provide incentives in order to stay competitive.

It is time to let value-based competition make an impact on health care.

What if, when going for an elective treatment such as a knee replacement, you are given options: health care professionals who provide high quality at high costs; those who provide low quality at low costs; and everything in between? Suddenly, you have information you need and a personal incentive to care.

Incentives are not just for consumers. In the future, incentives for doctors and hospitals will be part of the payment structure. Already, insurance plans and Medicare are experimenting with pay-for-performance incentives and competitive bidding for services where doctors and hospitals are rewarded for quality outcomes.

> ***"The American health care system is quietly imploding, and it's about time we did something about it."***
>
> **Lucian Leape**
> Harvard School of Public Health
> November 2005

Once transparency unveils price and quality information, and incentives are in place to drive quality-based decisions, real change starts to happen.

People need to know price and quality. People need to care about price and quality.

Interoperable Health Systems

Health information technology (IT) is an important cornerstone to reforming health care in America.

How often have you sat in a doctor's office, writing your health information on yet another set of paper forms? Waited for lab results to be sent to your doctor? Hand-carried X-rays from one office to another?

> ***"It's very scary to think that poor handwriting can easily result in a very grave outcome for a patient."***
> **Jean Stahl, Rph, South Dakota (Pharmacist)**

Electronic health records save everyone time and money. They reduce the chance of medical error. And when information can be shared electronically, they will impact every step in the health care process.

Sharing information requires interoperability. Big word, simple concept: it's what lets you use your bank card in ATMs virtually around the world. It will give us the same kind of access to our personal medical history.

Achieving interoperability means setting standards, so one system can talk to another, exchanging data accurately, efficiently, and securely.

Work is underway. The American Health Information Community, which includes representatives from health care professions, technology vendors, government agencies, employers and patients, was convened to advise in the development of health IT standards. We are close to adopting standards covering registration, lab results, prescription drugs, and secure information transfer.

There is a certification process to ensure these standards are being met. Nearly two dozen software systems are certified, with more on the way.

Interoperability will allow data to be aggregated, in an anonymous way, and analyzed. Connecting providers and payers across the nation will provide the reservoir of data necessary to dependably measure cost and quality.

That adds up to value and is critical to changing America's health care system.

Price Standards

Nothing but good comes from people knowing cost.

If we are to control health care costs — and we must — we first need to know what our costs are, and what we are getting for our money. But doing so is difficult. Beyond our insurance premiums and co-payments, none of us has a clue what we actually pay for health care.

The problem is that while a great deal of our spending is going to truly valuable treatments, too much is not. As a result, health care costs are higher than they need to be.

Price transparency requires gathering information from insurers and payers to provide relevant information to consumers. Wide participation is important, because a large body of information is needed to be able to draw valid price comparisons on specific treatments, hospitals, and doctors. To create an immediate critical mass, HHS is providing cost information on common inpatient and ambulatory services for our Medicare program.

> ***"This is the only industry where people are buying services without information. If we want people to become more engaged in thinking about what medical care costs, we have to change that."***
> **Dianne Kiehl, Executive Director**
> **Business Health Care Group of Southeast Wisconsin**

At the same time, insurers and payers are working to develop standards so that consumers can get a clearer idea of their overall costs of treatment for an episode of care – physicians, hospital services, lab tests, pharmacy, rehabilitation, etc.

We are all health care consumers. Informed consumer choice can create profound change.

The Future

There is no way today for a patient to compare the value of health care choices. In the future, people will get information that will allow them to compare cost, quality, and related facts necessary to find high-quality, low-cost health care. Likewise, physicians and hospitals will have the comparative information they need to improve.

Surgical Care Consumer Guide

Search Results: **Hip Replacement**

Summary

Average Cost in Network Facility: $11,249 - $15,895

Out of Network Facility : $18,889 - $23,460

What's included in the cost?

Results sorted by: Quality **Sort by:** Distance GO

Key

Quality: ★★★★ Highest | ★ Lowest **Cost:** $ Least Expensive | $$$$ Most Expensive **Patient Assessment:** ★★★★ Highest | ★ Lowest

Distance (miles)	Facility Name	Patients per year	Quality	Cost Estimate	Insurer Pays	Patient Pays	Patient Assessment of Care
6.2	Good Samaritan Hospital 1111 E. Samaritan Drive Tampa, FL 22222	232	★★★★	$$ $15,895	90% ($14,306)	10% ($1,590)	★★★★
13.2	All Saints Medical Center 123800 All Saints Way Tampa, FL 22122	86	★★★★	$$$ $20,700	80% ($16,560)	20% ($4,140)	★★★
25.6	Clearwater General 14280 Bay Drive Clearwater, FL 22131	400	★★★	$$ $15,895	85% ($13,511)	15% ($2,384)	★★
26.3	Tampa Hip Hospital 1400 East Tampa Boulevard Tampa, FL 22211	170	★★★	$$$ $20,700	75% ($15,525)	25% ($5,175)	★★★
27.3	Orthopedic Clinical Hospital 1444 Goodie Drive St. Petersburg, FL 22113	432	★★	$ $11,600	70% ($8,700)	25% ($2,900)	★
33.2	Valley General Hospital 1400 Tampa Bay Way Tampa Bay, FL 22031	135	★	$$$$ $22,000	70% ($15,400)	30% ($6,600)	★★

* Sample for illustrative purposes only.

1-8

Guide to Medicare's Preventive Services

This official government booklet explains...

- What prevention is and why it's important
- Which preventive services are new
- Which preventive services Medicare covers and how often
- Who can get them
- What you pay

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

House Health and Human Services
DATE: 1-25-07

ATTACHMENT 2-1

The best way to stay healthy is to live a healthy lifestyle. You can live a healthy lifestyle by exercising, eating well, keeping a healthy weight, and not smoking.

Another important way to stay healthy is to use preventive services provided by doctors and health care providers. Preventive services can find health problems early when treatment works best and can keep you from getting certain diseases or illnesses. Preventive services include exams, lab tests, and screenings. They also include shots, monitoring, and information to help you take care of your own health. Medicare pays for many preventive services to keep you healthy.

How Can this Booklet Help Me?

The preventive services listed in this booklet are covered no matter what kind of Medicare health plan you have. However, the amount you pay for these services varies depending on the type of health plan. This booklet explains the way preventive services are covered if you have Part B under the Original Medicare Plan (sometimes called fee-for-service). If you have another type of Medicare health plan, call your plan for more information.

This booklet can help you learn…

- How to stay healthy
- About these Medicare-covered services:
    - One-time "Welcome to Medicare" physical exam (if your Medicare Part B begins on or after January 1, 2005)
    - Cardiovascular screening
    - Tests for breast, cervical, vaginal, colorectal, and prostate cancers
    - Flu, pneumococcal, and Hepatitis B shots
    - Bone mass measurements
    - Diabetes screening and self-management
    - Glaucoma testing

Note: The information in this booklet was correct when it was printed. Changes may occur after printing. For the most current information, look at www.medicare.gov on the web. Select "Your Medicare Coverage." Or, call 1-800-MEDICARE (1-800-633-4227). A customer service representative can tell you if the information has been updated. TTY users should call 1-877-486-2048.

Table of Contents

Medicare's Guide to Preventive Services isn't a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

2 Medicare Preventive Services

Why Prevention is Important

You can stay healthy, live longer, and delay or prevent many diseases by…

- **exercising**—Do any physical activity you enjoy for 20–30 minutes 5 or 6 days a week.
- **eating well**—Eat a healthy diet of different foods like fruit, vegetables, protein (like meat, fish, or beans), and grains (like rice), and limit the amount of saturated fat you eat.
- **keeping a healthy weight**—Watch your portions, and try to balance the number of calories you eat with the number you burn by exercising.
- **not smoking**—Talk with your doctor about getting help to quit smoking.
- **getting preventive services**—Delay or lessen the effects of diseases by getting preventive services like shots to keep you from getting dangerous infections and screening tests to find diseases early.

Note: Talk to your doctor about the right exercise program for you.

Newly-covered Preventive Services

Medicare covers many different preventive services. Starting January 1, 2005, Medicare will now cover these three preventive services:

- One-time "Welcome to Medicare" Physical Exam (page 3)
- Cardiovascular Screening (page 4)
- Diabetes Screening to check for diabetes (page 10)

Keep reading to find out how Medicare covers these and other preventive services. You can also look at www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048.

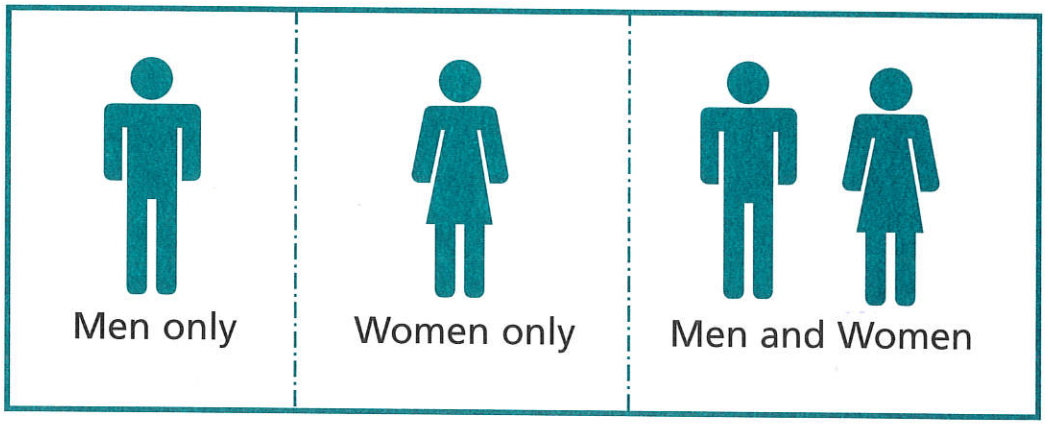
Talk to Your Doctor

In providing good care, your doctor or health care provider may do exams or tests that Medicare doesn't cover. Your doctor or healthcare provider may also recommend that you have tests more or less often than Medicare covers them. Talk to your doctor or health care provider to find out how often you need these exams to stay healthy.

Things to Know as You Read this Booklet

Symbols

You will see one of the following symbols next to each preventive service. It tells you for whom Medicare covers the test.



Risk Factors

You will also see lists of factors that increase your risk of developing a certain disease. If you're not sure if you're at high risk, talk to your doctor.

Part B Deductible

The Part B deductible in 2004 is $100 and will increase to $110 in 2005. This amount may change annually.

Medicare-approved Amount

The Medicare-approved amount is the amount Medicare pays for an item or service.

NEW - One-time "Welcome to Medicare" Physical

If your Medicare Part B coverage begins on or after January 1, 2005, Medicare will cover a one-time preventive physical exam **within the first six months that you have Part B.** The exam will include a thorough review of your health, education and counseling about the preventive services you need like certain screenings and shots, and referrals for other care if you need it. The "Welcome to Medicare" physical exam is a great way to get up-to-date on important screenings and shots and to talk with your doctor about your family history and how to stay healthy.

How often is it covered? One time only **within the first six months** that you have Part B

For whom? All people whose Medicare Part B begins on or after January 1, 2005

Your costs in the Original Medicare Plan? You pay 20% of the Medicare-approved amount after the yearly Part B deductible

NEW - Cardiovascular Screening

Medicare covers cardiovascular screenings that check your cholesterol and other blood fat (lipid) levels. High levels of cholesterol can increase your risk for heart disease and stroke. These screenings will tell if you have high cholesterol. You might be able to make lifestyle changes (like changing your diet) to lower your cholesterol.

What is covered? Tests for cholesterol, lipid, and triglyceride levels beginning January 1, 2005

How often is it covered? Talk with your doctor about how often

For whom? Talk with your doctor to see if you qualify

Your costs in the Original Medicare Plan? You pay nothing

Breast Cancer Screening Mammograms

Breast cancer is the most common non-skin cancer in women and the second leading cause of cancer death in women in the United States. Every woman is at risk, and this risk increases with age. Breast cancer can usually be successfully treated when found early. Medicare covers screening mammograms and digital technologies for screening mammograms to check for breast cancer before you or a doctor may be able to feel it.

How often is it covered? Once every 12 months

For whom? All women with Medicare age 40 and older can get a screening mammogram every 12 months. Medicare also pays for one baseline mammogram for women with Medicare between ages 35 and 39.

Your costs in the Original Medicare Plan? You pay 20% of the Medicare-approved amount with no Part B deductible

Are you at high risk for breast cancer?

Your risk of developing breast cancer increases if you…

- had breast cancer in the past
- have a family history of breast cancer (like a mother, sister, daughter, or two or more close relatives who have had breast cancer)
- had your first baby after age 30
- have never had a baby

Cervical and Vaginal Cancer Screening

Medicare covers Pap tests and pelvic exams to check for cervical and vaginal cancers. As part of the pelvic exam, Medicare covers a clinical breast exam to check for breast cancer.

How often is it covered? A Pap test and pelvic exam are covered by Medicare once every 24 months. However, if you are of childbearing age and have had an abnormal Pap test within the past 36 months, or if you are at high risk for cervical or vaginal cancer, Medicare will cover a Pap test and pelvic exam every 12 months.

For whom? All women with Medicare

Your costs in the Original Medicare Plan? You pay nothing for the Pap lab test. For Pap test collection and pelvic and breast exams, you pay 20% of the Medicare-approved amount with no Part B deductible.

Are you at high risk for cervical cancer?

Your risk for cervical cancer increases if …

- you have had an abnormal Pap test
- you have had cancer in the past
- you have been infected with the Human papillomavirus (HPV)
- you began having sex before age 16
- you have had many sexual partners
- your mother took DES (Diethylstilbestrol), a hormonal drug, when she was pregnant with you

Colorectal Cancer Screening

Colorectal cancer is usually found in people age 50 or older, and the risk of getting it increases with age. Medicare covers colorectal screening tests to help find pre-cancerous polyps (growths in the colon) so they can be removed before they turn into cancer. Treatment works best when colorectal cancer is found early.

How often is it covered?

- **Fecal Occult Blood Test**—Once every 12 months
- **Flexible Sigmoidoscopy**—Once every 48 months
- **Screening Colonoscopy** —Once every 24 months (if you're at high risk)

  Once every 10 years, but not within 48 months of a screening sigmoidoscopy (if you're not at high risk)
- **Barium Enema**—Your doctor can decide to use this test instead of a flexible sigmoidoscopy or colonoscopy. This test is covered every 24 months if you are at high risk for colorectal cancer and every 48 months if you aren't at high risk.

For whom? All people with Medicare age 50 and older, except there is no minimum age for having a screening colonoscopy

Your costs in the Original Medicare Plan? You pay nothing for the fecal occult blood test. For all other tests, you pay 20% of the Medicare-approved amount after the yearly Part B deductible.

If the flexible sigmoidoscopy or colonoscopy is done in a hospital outpatient department, you pay 25% of the Medicare-approved amount after the yearly Part B deductible.

Are you at high risk for colorectal cancer? Risk for colorectal cancer increases if you or a close relative have had colorectal polyps or colorectal cancer, or if you have inflammatory bowel disease (like ulcerative colitis or Crohn's disease).

Prostate Cancer Screening

Prostate cancer can often be found early by testing the amount of PSA (Prostate Specific Antigen) in your blood. Another way prostate cancer is found early is when your doctor performs a rectal exam. Medicare covers both of these tests so that prostate cancer can be detected and treated early.

How often is it covered?

- **Digital Rectal Examination**—Once every 12 months
- **Prostate Specific Antigen (PSA) Test**—Once every 12 months

For whom? All men with Medicare age 50 and older (coverage for this test begins the day after your 50th birthday)

Your costs in the Original Medicare Plan? Generally, you pay 20% of the Medicare-approved amount for the digital rectal exam after the yearly Part B deductible. There is no coinsurance and no Part B deductible for the PSA Test.

Are you at high risk for prostate cancer? While all men are at risk for prostate cancer, your risk increases if you have a father, brother, or son who has had prostate cancer. The list below shows the people at risk for prostate cancer from higher to lower amount of risk:

- African Americans
- Whites
- Hispanics
- Asians
- Pacific Islanders
- Native Americans

Shots (Flu, Pneumococcal, Hepatitis B)

Medicare covers flu, pneumococcal, and Hepatitis B shots. Flu, pneumococcal infections, and Hepatitis B can be life threatening to an older person. All adults 65 and older should get flu and pneumococcal shots. People with Medicare who are under 65 but have chronic illness, including heart disease, lung disease, diabetes or end-stage renal disease should get a flu shot. People at medium to high risk for Hepatitis B should get Hepatitis B shots.

Flu Shot

How often is it covered? Once a year in the fall or winter

For whom? All people with Medicare

Your costs in the Original Medicare Plan? You pay nothing

Pneumococcal Shot

How often is it covered? Most people only need this shot once in their lifetime

For whom? All people with Medicare

Your costs in the Original Medicare Plan? You pay nothing

Hepatitis B Shots

How often are they covered? Three shots are needed for complete protection. Check with your doctor about when to get these shots if you qualify to get them.

For whom? People with Medicare at medium to high risk for Hepatitis B

Your costs in the Original Medicare Plan? You pay 20% of the Medicare-approved amount after the yearly Part B deductible

Are you at high risk for Hepatitis B?

Common factors that put you at medium to high risk for Hepatitis B include…

- hemophilia
- End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)
- a condition that lowers your resistance to infection

Other factors may increase your risk for Hepatitis B. Check with your doctor to see if you are at medium to high risk for Hepatitis B.

Bone Mass Measurements

Medicare covers bone mass measurements to determine whether you are at risk for a fracture (broken bone). People are at risk for fractures because of osteoporosis. Osteoporosis is a disease in which your bones become weak. In general, the lower your bone density, the higher your risk is for a fracture. Bone mass measurement test results will help you and your doctor choose the best way to keep your bones strong.

How often is it covered? Once every 24 months (more often if medically necessary)

For whom? All people with Medicare who are at risk for osteoporosis

Your costs in the Original Medicare Plan? You pay 20% of the Medicare-approved amount after the yearly Part B deductible

Are you at risk for osteoporosis?

Your risk for osteoporosis increases if you…

- are age 50 or older
- are a woman
- have a family history of broken bones
- have a personal history of broken bones
- are White or Asian
- are small-boned
- have low body weight (less than about 127 pounds)
- smoke or drink a lot
- have a low-calcium diet

Diabetes Screening, Supplies, and Self-Management Training

Diabetes is a medical condition in which your body doesn't make enough insulin or has a reduced response to insulin. Diabetes causes your blood sugar to be too high because insulin is needed to use sugar properly. A high blood sugar level is not good for your health. For all people with Medicare, Medicare covers screenings to check for diabetes. For people with diabetes, Medicare covers certain supplies and self-management training to find and treat diabetes.

NEW - **Diabetes Screening (Fasting Plasma Glucose Test)** beginning January 1, 2005

How often is it covered? Talk with your doctor

For whom? Talk with your doctor

Your costs in the Original Medicare Plan? You pay nothing

Diabetes Glucose monitors, test strips, and lancets

For whom? All people with Medicare who have diabetes

Your costs in the Original Medicare Plan? You pay 20% of the Medicare-approved amount after the yearly Part B deductible

Diabetes Self-Management Training

For whom? This training is for certain people with Medicare who are at risk for complications from diabetes. Your doctor must request this service.

Your costs in the Original Medicare Plan? You pay 20% of the Medicare-approved amount after the yearly Part B deductible

For more information, get a free copy of *Medicare Coverage of Diabetes Supplies & Services* (CMS Pub. No. 11022) at www.medicare.gov on the web. Select "Publications." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Glaucoma Tests

Glaucoma is an eye disease caused by high pressure in the eye. It can cause you to gradually lose sight without warning and often without symptoms. The best way for people at high risk for glaucoma to protect themselves is to have regular eye exams.

How often is it covered? Once every 12 months

For whom? People with Medicare at high risk for glaucoma

Your costs in the Original Medicare Plan? You pay 20% of the Medicare-approved amount after the yearly Part B deductible

Are you at high risk for glaucoma?

Your risk for glaucoma increases if you…

- have diabetes
- have a family history of glaucoma
- are African American and age 50 or older

For More Information

You can learn more about Medicare's preventive services by looking at www.medicare.gov on the web, or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

(2)
Rob Epps

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Official Business
Penalty for Private Use, $300

Publication No. CMS - 10110
Revised August 2004

Medicare is here for you 24 hours a day, every day.

For help with your Medicare questions

- visit www.medicare.gov
- call 1-800-MEDICARE (1-800-633-4227)
- call 1-877-486-2048 (TTY users)

To get this booklet in Spanish, call 1-800-633-4227. TTY users should call 1-877-486-2048.

Para conseguir este folleto en español llame gratis al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deben llamar al 1-877-486-2048.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

2-14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families
Office of Child Support Enforcement Region VII
January 2007

Child Support Enforcement Provisions of the Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005, Public Law 109-171, was signed into law by the President on February 8, 2006. There are eleven sections of the law in Title VII, Subtitle C, relevant to the Child Support Enforcement Program. On January 24, 2007, a Notice of Proposed Rulemaking was issued by the US Department of Health and Human Services covering a number of these provisions.

Funding Provisions

Ending Federal Matching of State Spending of Federal Incentive Payments

Effective October 1, 2007, states are no longer allowed to use performance incentive funds as the state share for purposes of claiming 66% IV-D FFP. The Congressional Budget Office (CBO) projected a reduction in child support collections due to this provision. For Kansas, CBO estimated a loss of $21.1 million in collections over a five year period from 2006 to 2010 if the State replaces half of the federal reduction in FFP.

Mandatory Fees for Successful Child Support Collection for a Family that has Never Received TANF Assistance

Effective October 1, 2006, States are required to begin charging families that have never received TANF assistance an annual fee of $25 if the state collects at least $500 in support payments. Because State legislation is needed in Kansas, the effective date is delayed to October 1, 2007.

Reduction in Federal Matching Rate for Lab Costs Incurred in Determining Paternity

Beginning October 1, 2006, the federal matching rate for the costs of genetic testing to determine paternity will be reduced from the enhanced 90% matching rate to the regular matching rate of 66%.

Substantive Provisions

Assignment and Distribution of Child Support Payments

At State option, these provisions are intended to increase child support payments to families and simplify distribution of support.

- Amends TANF assignment requirement to only those payments that accrue while the family is receiving assistance. State option to discontinue certain assignments.
- Provides State option to pass through collections to families on TANF and disregard those amounts in determining eligibility and benefits. Effective 2009.
- For families formerly on TANF, provides State options to distribute more or all support to families without owing the federal share. Effective 2009 or 2010 at State election.

House Health and Human Services
DATE: 1-25-07
ATTACHMENT 3-1

Child Support Enforcement Provisions
of the Deficit Reduction Act of 2005
January 2007

Requirement that State Child Support Agencies Seek Medical Support from Either Parent

Effective October 1, 2005, States are required to have in effect laws requiring all child support orders to include a provision for medical support to be provided by either or both parents. States may enforce medical support orders against custodial parents.

Information Comparisons with Insurance Data

Effective October 1, 2005, HHS is authorized to conduct a new data match at the national level between delinquent obligors and potential insurance claims, settlements, awards and payments. Information is then transmitted to the States. Under this provision, the insurer is protected from liability.

Expansion of the Federal Tax Refund Offset Program

Beginning October 1, 2007, States will be allowed to use of the federal tax refund intercept program to collect past-due child support for families on behalf of any child, whether or not a minor.

Decrease in Amount of Child Support Arrearage Triggering Passport Denial

Starting October 1, 2006, the amount of arrearage owed that determines when a State may invoke passport denial is reduced from $5000 to $2500.

Mandatory Review and Adjustment of Orders for Families Receiving TANF

Effective October 1, 2007, States will be required to conduct modifications of the support amounts ordered in all TANF cases at least once every three years.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Administration for Children and Families
Office of Child Support Enforcement Region VII
January 2007

The Kansas Child Support Enforcement (CSE) Program
Summary of Key State and Federal Data

Federal Performance Incentive Indicators – 2005

Paternity Establishment Percentage	2005
Kansas	91.2
National Average	87.6

Percent of Cases with Court Orders Established	2005
Kansas	74.4
National Average	75.9

Percent of Current Collections	2005
Kansas	54.5
National Average	59.9

Percent of Cases with an Arrears Collection	2005
Kansas	62.6
National Average	60.0

Cost Effectiveness (Total collected for every $1 expended)	2005
Kansas	$3.39
National Average	$4.58

Federal Performance Incentives paid to Kansas for 2005 -- $3,289,970

Child Support Payments Collected and Distributed - 2006:
$157,720,315

Annual Administrative Expenditures - 2006:
Total Kansas IV-D Costs Claimed: $52,923,770
Federal Share: $34,985,378

Caseload - 2006:
Current Assistance: 26,193
Formerly Assistance: 64,354
Never Assistance: 40,282
Total: 130,829

Source: OCSE Preliminary Data Report June 2006; OCSE 157, line 1; OCSE 34A line 8; and OCSE 396A, line 9.

House Health and Human Services
DATE: 1-25-07
ATTACHMENT 4-1

DEPARTMENT OF HEALTH & HUMAN SERVICES
Administration for Children and Families
Region VII
January 2007

The Kansas Temporary Assistance for Needy Families (TANF) Program
Summary of Key State and Federal Data

TANF Block Grant: $101,931,061

Maintenance of Effort	
100%	$82,332,787
80%	$65,866,230
75%	$61,749,590

Work Participation Rates

Fiscal Year	All-Family Rate and Goal		2-Parent Rate and Goal	
2004	88.0%	37.6%	93.7%	77.6%
2005 *	86.7%	38.8%	92.8%	78.8%
2006 *	77.2%	38.8%	82.3%%	78.8%

TANF Financial Data – FY 2005

Federal Funds Available: $107,243,962

Transfers:

Transferred to:		
CCDF	$21,459,991	20%
SSBG	$4,332,070	4%

Funds Available for TANF: $81,494,750

Expenditure Breakdown:

Assistance	$58,166,606
Non-Assistance	$22,552,452

Total MOE Expenditures: $73,582,933

MOE Assistance	$40,435,484
MOE Non-Assistance	$33,147,449

* FY 2005 and 2006 Participation Rates not yet certified by Office of Family Assistance

AOA DATA SHEET (DATA FOR FY 2004)

Who We Are:

56 State Agencies | 238 tribal organizations | 655 area agencies
29,000 providers | 500,000 volunteers
13,000 Ombudsman volunteers

Who We Serve:

8 million elders – 17% of all elders 60 and over
3 million elders receive intensive services (e.g. personal care, adult day care, home-delivered meals)
Over 2 million elderly below poverty; 1.8 million minority elderly;
Almost 2.2 million rural elderly
1.8 million elders served in congregate nutrition sites (senior centers)
Almost 1 million elders receive home-delivered meals
600,000 caregivers provided access assistance
310,000 caregivers provided training and counseling
50,000 Native Americans provided congregate meals
33,000 Native Americans provided home-delivered meals
190,000 Ombudsman cases opened; 185,000 cases closed

What We Provide:

143 million home-delivered meals; 2.2 million for Native Americans
105 million congregate meals; 1.4 million for Native Americans
36 million rides each year; 735,000 for Native Americans
Over 29 million hours combined for personal care, homemaker, and adult-day care services; almost 1 million for Native Americans
4 million hours of case management to over 400,000 elders
Almost 2 million outreach contacts a year
Over 13 million information and assistance service contacts
Ombudsman program handled 290,000 complaints

Our Results:

Targeting:

10% of U.S. elders are below poverty; 28% of OAA clients are below poverty.
24% of elders are rural; over 27% of OAA clients are rural.
16% of elders are minority; 22% of OAA clients are minority.

Leveraging:

Overall, States and area agencies leverage $2 for every $1 from the OAA.
For intensive services, States and area agencies leverage $3 to every OAA dollar.

Systems:

37% of area agency staff are volunteers.
76% of senior centers are community focal points.
Ombudsmen resolve/partially resolve 78% of complaints.
SMP projects generated 3,100 substantiated health care fraud cases.

Consumer Outcomes (annual outcome survey data):

- 88% of caregivers say services allow them to care for elderly longer.
- 33% of elderly transportation recipients rely on the service for virtually all of their transportation needs.
- 76% of transportation clients would recommend service to friends.
- 75% of new home-delivered meals clients are at high nutritional risk.
- 95% of home-delivered meals clients like the meals and the people who deliver them.
- 85% of homemaker clients say workers are thorough and that work is done the way they want it done.
- 71% of homemaker clients were over 70 years old; the same percentage lived alone.
- 85% of information seekers report they get the information they needed.
- 94% of information seekers said their call was answered within 5 rings.
- 86% of callers reported the call was answered by a person, not a machine.

House Health and Human Services
DATE: 1-25
ATTACHMENT 5