Approved: April 2, 2007
Date

MINUTES OF THE HOUSE SOCIAL SERVICES BUDGET COMMITTEE

The meeting was called to order by Chairman Bob Bethell, at 3:30 P.M. on March 22, 2007 in Room 231-N of the Capitol.

All members were present except:
Pat George- excused

Committee staff present:
Susan Kannarr, Kansas Legislative Research Department
Amy Deckard, Kansas Legislative Research Department
Amy VanHouse, Kansas Legislative Research Department
Emalene Correll, Kansas Legislative Research Department
Jim Wilson, Office of Revisor of Statutes
Kay Dick, Committee Assistant

Conferees appearing before the committee:
Karla Finnell, Exe. Director KS Assoc. For the Medically Underserved (KAMU)
Representative Jeff Colyer
Gregory Schneider, Flint Hills Center for Public Policy
Brad Harrelson, Kansas Farm Bureau
Jerry Slaughter, Kansas Medical Society (KMS)
Dr. Marcie Nielsen, Exe. Director, Kansas Health Policy Authority (KHPA)
Representative Jeff King
Larry Ann Lower, Kansas Assoc. Of Health Plan
Callie Benton-Walter, KTLA

Others attending:
See attached list.

Chairman Bethell called the meeting to order at 3:30 p.m. Drawing the Committee's attention to the report on **HB 2236** - Geriatric mental health act, which the Committee is going to ask for an Interim. (Attachment 1)

Discussion and Action on HB 2144 - Nursing facility reimbursement rates, rolling base year.

Chairman Bethell pointed out that each member had information from the Kansas Department of Aging that answers the question that he asked of them which is "the cost coverage of nursing reimbursement rates." (Attachment 2) He goes on to indicate that the Committee had similar information from the Kansas Health Care Association. (Attachment 3).

Representative Kelsey made a motion to move **HB 2144** out of Committee. Representative Ballard seconded the motion. The motion carried.

Discussion and Action on HB 2547 - Primary care safety net clinic capital loan guarantee act.

Representative Kelsey made a motion to report **HB 2547** out favorably. Representative Mast seconded the motion. Karla Finnell, (KAMU), presented purposed amendments before the Committee with Nine (9) Comments to be added or changed. (Attachment 4) Following discussion of the different amendments and with the help on wording from Jim Wilson, Office of Revisor's Statutes, Representative Mast moved to accept the amendments. It was seconded by Representative Henry. The amendments were accepted.

Representative Mast moved to pass **HB 2547** favorably as amended. Representative Ballard seconded the motion. Motion passed to send **HB 2547** back to the Appropriations Committee as a whole.

MINUTES OF THE House Social Services Budget Committee at 3:30 P.M. on in Room231-N of the Capitol.

Hearing on: HB 2591 - Enacting the foundations of health reform act of 2007, including medicaid reform and insurance reform.

Chairman Bethell opened the hearing, asking Susan Kannarr, Legislative Research Department, to give the Committee an overview of **HB 2591**. She stated that this is a lengthy bill (58 pages) and would try and give the high points of **HB 2591**. Susan explain the new sections to the committee.

The Chair recognized Representative Jeff Colyer. The Representative testified in favor of **HB 2591** which begins serious health reform this year. He stated that there are several groups which are considering aspects of health reform. This bill should be viewed as foundational and complimentary to the efforts of the Senate, KHPA and elsewhere. Representative Colyer pointed out that the bill sets in motion foundational reforms in 4 areas: 1) Making commercial insurance more available and affordable. 2) Expediting the transformation of government financed health care. 3) Creating methods to help Medicaid and uninsured to obtain stable private insurance. 4) Help the safety net for the uninsured. (Attachment 5) Representative Colyer also introduced a proposed amendment adding a new section and renumbering the other. (Attachment 6)

The Chairman welcomed Gregory Schnieder, Flint Hills Center for Public Policy, who testified as a proponent for **HB 2591**. Mr. Schneider stated that this is the most comprehensive reform of Medicaid among several proposal in the legislature this year. **HB 2591** contains several features which Flint Hills endorses. He goes on to say the most innovative and important part of the bill concerns the establishment of a nonprofit Kansas Insurance Exchange Association. (Attachment 7)

Chairman Bethell recognized Karla Finnell, KAMU, a proponent for **HB 2591**. Ms. Finnell encouraged stakeholders and advocates to seek compromise to obtain the effective reforms for the most people. She commented on the programs for the uninsured. The use of technology. Incentive-based systems. Maintaining cost-based reimbursements. Sustaining effective programs for Native American populations. And charitable health care facilities. (Attachment 8)

Brad Harrelson, Kansas Farm Bureau, testified as a proponent replacing scheduled Terry Holdren, who had other commitments. Mr. Harrelson stated that KFB supports rational, market based solutions that would provide options and enhance convenience for Kansas citizens. He also spoke in favor of **HB 2591** emphasizing that it would provide immediate help fore KFB members and others who are currently not able to pool their risk in an association or limit their cost by shopping for alternatives to traditional insurance products. (Attachment 9)

The Chair recognized Jerry Slaughter, Kansas Medical Society. Mr. Slaughter testified in support of the health care reform foundation of **HB 2591**. (No written testimony)

Dr. Marcie Nielsen, KHPA, shared some of the concerns she had with **HB 2591**. Dr. Nielsen stated that she was very pleased that significant attention is being paid to the importance of providing affordable access to health care in Kansas, she does not support this legislation in its existing form. She pointed out that the bill contained 58 pages, assuming that the committee, like themselves and others have not had proper time to read nor digest the contents of **HB 2591**. Dr. Nielsen went on to say that it would be very difficult, after only nine months of being in operation, for KHPA to implement all of the requirements as the legislation is surprisingly broad in nature and convoluted in approach. In closing she asked the Committee to oppose this legislation. (Attachment 10)

The Chairman recognized Representative Jeff King who testified in support of **HB 2591** sighting special interest in the new Sec. 21. (No written testimony)

Larry Ann Lower, offered assistance in support of **HB 2591** (No written testimony)

Callie Benton-Walter spoke in support of **HB 2591** pointing out Section 17 - Limitations on liabilities. (No written testimony)

MINUTES OF THE House Social Services Budget Committee at 3:30 P.M. on in Room231-N of the Capitol.

Chairman Bethell closed hearing on HB 2591.

Discussion and Action on HB 2591 - Enacting the foundations of health reform act of 2007, including medicaid reform and insurance reform.

Representative Mast moved to pass **HB 2591** out of committee. Representative Rhoades seconded the motion.

Representative Mast made a motion to put proposed amendment with new section into **HB 2591**. Representative Crum seconded the motion. Motion passed.

Representative Mast made a motion to strike everything in **SB 11** and replace it with **HB 2591.** Representative Kelsey seconded the motion.

Following discussion **House Substitute for SB 11** passed.

Representative Ballard and Representative Henry asked to be recorded as a "NO" vote.

Meeting was adjourned.

SOCIAL SERVICE BUDGET COMMITTEE GUEST LIST

DATE: MARCH

NAME	REPRESENTING
Cindy Luxem	Kansas Health Care Assoc.
[illegible]	KAHSA
Greg Schneider	Flint Hills Center
Dan Murray	Federico Consulting
Jim McLean	KHI
Sheedan Weisgrau	KHI
Sarah C. Hazell	KHI
Jeff Colyer	
[illegible]	[illegible]
Kathy Sweeden	KDOA
DAN MORIN	KS Medical Society
[illegible]	KAIA
Bill Sneed	KWP
Chad Austin	KHA
Nancy Pierce	KHCA
[illegible]	KAHSA
BRAD HARRELSON	KFB
Mike Hutfles	KAMU
Bob Sampson	KHPA
Karla Finell	KAMU
[illegible]	KAMU
[illegible]	
Peggy Mahrin	BCBS KC
[illegible]	United Healthcare

The House Social Services Budget Committee recommends that the topic of mental health services for the elderly, including the provisions of 2007 HB 2236 which would establish the Geriatric Mental Health Act, be reviewed during the Interim.

Medicaid Gap Between Costs and Rates using Actual Costs for 2003

	A	B	C	D	E	F	G	H
1								
2								
3				AVERAGE	AVERAGE		Medicaid	7/1/200
4			Facility	MEDICAID RATE	MEDICAID COST	DIFFERENCE	Percentage	Private P
5	Rep.	District						
6								
7	Bethell	113	Woodhaven Care Center	91.57	111.45	(19.88)	56.75%	102
8	Bethell	113	Cheyenne Meadows Living Center	82.39	101.86	(19.47)	58.33%	89
9								
10	Mast	76	Life Care Center of Burlington	99.41	111.07	(11.66)	50.38%	105.43
11	Mast	76	Holiday Resort	94.66	136.04	(41.38)	57.09%	108.35
12								
13	Crum	77	Medicalodge of Douglass	96.69	128.85	(32.17)	69.51%	107.16
14	Crum	77	Lakepoint Nursing Ctr-Rose Hill	100.03	115.20	(15.18)	66.30%	102.04
15								
16	George	119	Trinity Manor	107.58	134.44	(26.86)	52.56%	111.65
17								
18	Kelsey	93	Medicalodge of Goddard	117.68	148.44	(30.77)	58.05%	117.43
19	Kelsey	93	Haysville Healthcare Center	106.60	121.64	(15.04)	70.17%	119.84
20								
21	Rhoades	72	Newton Presbyterian Manor	125.56	165.05	(39.49)	40.94%	135.60
22								
23	Henry	63	Highland Care Center	99.56	111.25	(11.69)	47.33%	109.00
24	Henry	63	Medicalodge of Atchison	102.98	125.88	(22.90)	64.84%	112.45
25								
26	Hawk	67	Stoneybrook Retirement Commun	108.13	122.33	(14.20)	41.04%	121.31
27								
28								
29								
30								
31	Source: 2003 CRDL from KDOA							

House Social Service Budget Committee
Date 3-22-07
Attachment # 2

Medicaid Gap Between Costs and Rates using Actual Costs for 2004

	A	B	D	E	F	G	H	I
1								
2								
3				AVERAGE	AVERAGE		Medicaid	7/1/2004
4			Facility	MEDICAID RATE	MEDICAID COST	DIFFERENCE	Percentage	Private Pay
5	Rep.	District						
6								
7	Bethell	113	Woodhaven Care Center	98.77	109.13	(10.36)	56.84%	102.80
8	Bethell	113	Cheyenne Meadows Living Center	85.69	106.79	(21.11)	58.33%	89.62
9								
10	Mast	76	Life Care Center of Burlington	108.94	110.50	(1.56)	53.71%	115.33
11	Mast	76	Holiday Resort	101.15	126.37	(25.22)	55.46%	125.06
12								
13	Crum	77	Medicalodge of Douglass	108.43	141.00	(32.57)	65.77%	130.22
14	Crum	77	Lakepoint Nursing Ctr-Rose Hill	104.10	129.89	(25.79)	59.46%	110.63
15								
16	George	119	Trinity Manor	109.08	135.26	(26.18)	54.06%	113.68
17								
18	Kelsey	93	Medicalodge of Goddard	121.88	151.35	(29.47)	57.57%	126.33
19	Kelsey	93	Haysville Healthcare Center	107.73	124.63	(16.90)	64.74%	145.28
20								
21	Rhoades	72	Newton Presbyterian Manor	125.52	170.17	(44.66)	44.49%	146.79
22								
23	Henry	63	Highland Care Center	103.68	139.77	(36.10)	32.70%	109.02
24	Henry	63	Medicalodge of Atchison	107.39	121.19	(13.80)	64.28%	116.35
25								
26	Hawk	67	Stoneybrook Retirement Commun	114.39	150.97	(36.58)	49.48%	129.93
27								
28								
29								
30								
31	Source: 2004 CRDL from KDOA							

Medicaid Gap Between Costs and Rates using Actual Costs for 2005

	A	B	D	E	F	G	H	I
1								
2								
3				AVERAGE	AVERAGE		Medicaid	7/1/2005
4			Facility	MEDICAID RATE	MEDICAID COST	DIFFERENCE	Percentage	Private Pay
5	Rep.	District						
6								
7	Bethell	113	Woodhaven Care Center	102.12	107.46	(5.34)	48.57%	102.80
8	Bethell	113	Cheyenne Meadows Living Center	90.40	105.56	(15.16)	54.96%	100.00
9								
10	Mast	76	Life Care Center of Burlington	117.63	122.05	(4.42)	47.80%	120.40
11	Mast	76	Holiday Resort	106.44	135.48	(29.04)	52.76%	136.67
12								
13	Crum	77	Medicalodge of Douglass	129.80	152.81	(23.01)	56.96%	159.96
14	Crum	77	Lakepoint Nursing Ctr-Rose Hill	111.66	131.29	(19.63)	58.07%	118.11
15								
16	George	119	Trinity Manor	111.11	155.35	(44.24)	59.79%	124.95
17								
18	Kelsey	93	Medicalodge of Goddard	127.41	153.94	(26.53)	51.35%	126.33
19	Kelsey	93	Haysville Healthcare Center	110.99	129.29	(18.30)	63.18%	151.31
20								
21	Rhoades	72	Newton Presbyterian Manor	128.74	173.49	(44.75)	54.25%	157.00
22								
23	Henry	63	Highland Care Center	103.94	167.42	(63.48)	38.44%	109.02
24	Henry	63	Medicalodge of Atchison	111.41	123.46	(12.06)	57.40%	116.35
25								
26	Hawk	67	Stoneybrook Retirement Commun	119.07	142.51	(23.44)	54.77%	150.06
27								
28								
29								
30								
31	Source: 2005 CRDL from KDOA							

Info re: need for Rebasing - HB 2144

Large Facilities

Name of Facility	Fac. #	Cost/Day	Reimbursement/Day	Percentage covered
Catholic Care	10646	139.79	138.25	0.988983475
Aldersgate	21110	201.12	144.8	0.719968178
Bethany	15890	143.67	139.48	0.970835943
Garden Valley	11344	132.61	142.09	1.071487821
Jo.Co. N.Ctr.	21109	164.53	154.23	0.937397435
Villa St. Francis	10668	154.45	136.69	0.885011331
			Average	**0.928947364**

Small Facilities

The Shepherd Ctr	18308	$107.31	$116.65	1.087037555
Newton Presb.	10051	$144.81	$132.57	0.915475451
Atchison Sr.	15023	$131.59	$134.39	1.021278213
Dooley	21222	$154.76	$133.07	0.859847506
Kidron	15585	$142.20	$140.13	0.985443038
Howard Twilight	15394	$124.05	$123.70	0.997178557
			Average	**0.977710053**

Average of Large + Small **0.953328709**

Session of 2007

HOUSE BILL No. 2547

By Committee on Appropriations

2-21

AN ACT enacting the primary care safety net clinic capital loan guarantee act; prescribing powers, duties and functions for the secretary of health and environment; establishing the primary care safety net clinic loan guarantee committee and funds.

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

Section 1. The provisions of sections 1 through 7 and amendments thereto shall be known and may be cited as the primary care safety net clinic capital loan guarantee act.

Sec. 2. As used in the primary care safety net clinic capital loan guarantee act:

(a) "Act" means the primary care safety net clinic capital loan guarantee act;

(b) "community health center" means an entity that receives funding under section 330 of the federal health center consolidation act of 1996 and meets all of the requirements of 42 USC section 254b, relating to serving a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal agricultural workers, the homeless, and residents of public housing, by providing, either through staff and supporting resources of the center or through contracts or cooperative arrangements, all required primary health services as defined by 42 USC section 254b;

(c) "federally-qualified health center look-alike" means an entity which has been determined by the federal health resources and services administration to meet the definition of a federally qualified health center as defined by section 1905(l)(2)(B) of the federal social security act, but which does not receive funding under section 330 of the federal health center consolidation act of 1996;

(d) "financial institution" means any bank, trust company, savings bank, credit union or savings and loan association or any other financial institution regulated by the state of Kansas, any agency of the United States or other state with an office in Kansas which is approved by the secretary for the purposes of this act;

(e) "indigent health care clinic" means an outpatient medical care clinic operated on a not-for-profit basis which has a contractual agreement

in effect with the secretary of health and environment under K.S.A. 75-6120 and amendments thereto to provide health care services to medically indigent persons;

(f) "loan transaction" means a transaction with a financial institution to provide capital financing for the renovation, construction, acquisition, modernization, leasehold improvement or equipping of a primary care safety net clinic;

(g) "medically indigent person" means a person who lacks resources to pay for medically necessary health care services and who meets the eligibility criteria for qualification as a medically indigent person established by the secretary of health and environment under K.S.A. 75-6120 and amendments thereto;

(h) "primary care safety net clinic" means a community health center, a federally-qualified health center look-alike or an indigent health care clinic; and

(i) "secretary" means the secretary of health and environment.

Sec. 3. (a) ~~Subject to the provisions of the appropriations acts,~~ the secretary is hereby authorized to enter into agreements with primary care safety net clinics, financial institutions, and other public or private entities, including agencies of the United States government to provide capital ~~loan guarantees against risk~~ of default for eligible primary care safety net clinics in Kansas in accordance with this act.

(b) To be eligible for a capital loan guarantee under this act, a primary care safety net clinic shall offer a sliding fee discount for health care and other services provided that is based upon household income and shall serve all persons regardless of ability to pay. The policies to determine patient eligibility based upon income or insurance status may be determined by each primary care safety net clinic, but shall be posted in the primary care safety net clinic and available to potential patients. The patient eligibility policies of a primary care safety net clinic shall reflect the mission of the primary care safety net clinic to provide affordable, accessible primary care to underserved populations in Kansas to be eligible for a capital loan guarantee under this act.

(c) The secretary shall administer the provisions of this act and ~~shall~~ adopt rules and regulations which the secretary deems necessary for the implementation or administration of this act. The ~~rules and regulations~~ shall include reporting requirements ~~and financial covenants, including reasonable financial performance covenants that are~~ appropriate for the type of loan for the borrower. The Secretary may enter into contracts that the secretary deems necessary for the implementation or administration of this act.

Sec. 4. (a) Each agreement entered into by the secretary to guarantee against default on a loan transaction shall be backed by the primary

Comment [t1]: Insert after financial institution, or the Kansas Development Finance Authority

Comment [t2]: Insert-Kansas Development Finance Authority after private entities but before agencies on line 20.

Comment [t3]: No claim against the State under this act shall be paid by the state or the agency except by appropriation act of the Legislature as per an approved claim filed against the Joint Committee on Special Claims.

Comment [t4]: 1. Replace shall will may on line 34. That is the secretary shall administer the provisions of this act and may adopt regulations..

Comment [t5]: Replace shall with may.

Comment [t6]: Line 36 and 37. Modify sentence to state as follows: The loan guarantee agreement shall include reporting requirements and financial standards appropriate for the type of loan for the borrower.

Comment [t7]: The secretary may enter into agreements and contracts that the secretary deems necessary for the implementation or administration of this act. The secretary may impose such fees and charges as may be necessary to administer the provisions of this act.

care safety net capital loan guarantee fund and shall receive prior approval by the primary care safety net clinic loan guarantee review committee established under section 5, and amendments thereto.

(b) Each loan transaction eligible for a guarantee under this act shall be for renovation, construction, acquisition, modernization, leasehold improvement or equipping of a primary care safety net clinic. Eligible costs may include land and building purchases, renovation and new construction costs, equipment and installation costs, pre-development costs that may be capitalized, financing, capitalized interest during construction, limited working capital during a start-up phase and consultant fees which do not include staff costs.

(c) The aggregate principal amount of outstanding loan guarantees for any single borrowing organization shall not exceed $3,000,000. The aggregate outstanding amount of all loan guarantees for borrowing organizations~~, including accrued interest~~, under this act shall not exceed ~~$25,000,000~~ at any time.

Comment [t8]: Replace $25M with $15M

(d) Eligible tax-exempt bonds or conventional loans may be guaranteed up to 100% under this act, subject to the other provisions of this act and the rules and regulations adopted by the secretary of health and environment therefor. Each eligible loan transaction shall require an equity investment by the borrowing organization and shall have a loan-to-value ratio of at least 66%.

(e) The maximum term for an eligible loan transaction under this act for machinery or equipment shall be 10 years. The maximum term for an eligible loan transaction under this act for renovation, remodeling or leasehold improvements shall be 10 years. The maximum term for an eligible loan transaction under this act for new construction or land acquisition shall be 25 years.

Sec. 5. (a) There is hereby established the primary care safety net clinic loan guarantee review committee within the department of health and environment. The committee shall consist of five members.

(b) The members of the primary care safety net clinic loan guarantee review committee shall be appointed by the secretary in accordance with the following: (1) Two members shall be representatives of the department of health and environment selected by the secretary, (2) one member shall be appointed by the secretary ~~from among a~~ list ~~of persons nominated~~ by the Kansas development finance authority, (3) one member shall be appointed by the secretary from among a list of persons nominated by the Kansas health policy authority, and (4) one member shall be appointed by the secretary from among a list of persons nominated by the Kansas association for the medically underserved.

(c) The secretary may appoint persons as members of the primary care safety net clinic loan guarantee review committee who are officers

or employees of the agencies or organizations they are nominated by or that they are appointed to represent. Not more than three members of the committee shall be affiliated with the same political party. Members shall serve at the pleasure of the secretary.

(d) The primary care safety net clinic loan guarantee review committee shall review all proposals for loan financing guarantees under this act and shall approve those proposals that the committee deems to represent reasonable risks and to have a sufficient likelihood of repayment. The committee shall advise the secretary on matters regarding the administration of this act when requested by the secretary and may provide such advice when deemed appropriate by the committee.

(e) The secretary or the secretary's designee shall serve as a nonvoting chairperson of the primary care safety net clinic loan guarantee review committee, and the committee shall annually elect a vice-chairperson from among its members. The committee shall meet upon call of the chairperson or upon call of any two of its members. Three voting members shall constitute a quorum for the transaction of business.

(f) Members of the primary care safety net clinic loan guarantee review committee attending meetings of the committee, or attending a subcommittee meeting thereof authorized by the committee, shall be paid compensation, subsistence allowances, mileage and other expenses as provided in K.S.A. 75-3223 and amendments thereto.

Sec. 6. (a) There is hereby established the primary care safety net clinic loan guarantee fund in the state treasury for the purposes of facilitating the financing for the acquisition and modernization of primary care safety net clinics in Kansas and the refinancing of capital improvements and acquisition and installation of equipment therefor. The primary care safety net clinic loan guarantee fund shall be administered by the secretary. All moneys in the primary care safety net clinic loan guarantee fund shall be used to provide guarantees against capital loan risks in accordance with this act. All expenditures from the primary care safety net clinic loan guarantee fund shall be made in accordance with appropriations acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the secretary or the secretary's designee.

(b) All moneys received by the secretary for the purposes of this act shall be remitted to the state treasurer in accordance with the provisions of K.S.A. 75-4215, and amendments thereto. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount in the state treasury to the credit of the primary care safety net clinic loan guarantee fund.

(c) Upon certification by the secretary to the director of accounts and reports that the unencumbered balance in the primary care safety net clinic loan guarantee fund is insufficient to pay an amount for a loan

Comment [t9]: and to pay for the administration costs association with loan guarantee program as may be certified by the secretary

guarantee for which the fund is liable under this act, the director of accounts and reports shall transfer an amount equal to the insufficiency from the state general fund to the primary care safety net clinic loan guarantee fund. The secretary shall transmit a copy of each such certification to the director of the budget and to the director of legislative research at the same time that the secretary submits a certification to the director of accounts and reports under this subsection.

(d) On or before the 10th of each month, the director of accounts and reports shall transfer from the state general fund to the primary care safety net clinic loan guarantee fund interest earnings based on:

(1) The average daily balance of moneys in the Kansas export loan guarantee fund for the preceding month; and

(2) the net earnings rate of the pooled money investment portfolio for the preceding month.

Sec. 7. The secretary shall prepare an annual report of the loan guarantee activity under this act, including new loans, loan repayment status and other relevant information regarding activities under this act and shall submit the report of its activities to the legislature at the beginning of each regular session by submitting the annual report to the committee on ways and means of the senate, or to the appropriate subcommittee thereof, or to its successor committee, and to the committee on appropriations of the house of representatives, or to the appropriate budget committee, or its successor committee.

Sec. 8. This act shall take effect and be in force from and after its publication in the statute book.

TESTIMONY OF REPRESENTATIVE JEFF COLYER

HB 2591 Foundations of Health Reform Act of 007

House Committee on Social Services Budget

March 22, 2007

Dear Mr. Chairman and Members of the Committee,

Thank you for the opportunity to visit with you about HB2591 which begins serious health reform this year. There are several groups which are considering aspects of health reform. This bill should be viewed as foundational and complimentary to the efforts of the Senate, KHPA, and elsewhere.

Majority Leader Merrick named a Republican Task Force to look at reform now. This committee heard from several national and local experts on various health aspects. In addition we have paid attention to the previous and current efforts outside of the Task Force. Nobody has all the answers.

Over the last few weeks there has been criticism that the Legislature has not begun to enact meaningful health reform now. All of us spent last summer and fall on the doorsteps of our constituents and know first hand that the public expects real efforts at reform. We should not let Kansans down.

One way of looking at Health in Kansas is that it is built on a wobbly three legged stool. The number of uninsured in Kansas is 10.9% and essentially unchanged. The number of Kansans covered by private insurance has decreased to 65% while we have expanded the number on government insurance to around 23%. We need to deal with all areas to shift the trend lines in the right direction. We are not in as dire straights as Massachusetts or California which want to impose mandates and new taxes, but those days could be ahead.

It will take several years to reform 16% of the GDP. There have been lots of ideas over the years and we need to start now for a number of reasons.

1) The many issues have been vented over the years and Kansans expect us to start.
2) The federal Department of Health and Human Services, the Health Policy Authority and the Legislature need to participate on Medicaid transformation. If we begin the process now, we will not be held up by changeover with next year being an election year.
3) The costs of inaction both human and financial continue to mount.

The bill before you sets in motion foundational reforms in 4 areas:

1) Making commercial insurance more available and affordable
2) Expediting the transformation of government financed health care
3) Creating methods to help Medicaid and uninsured to obtain stable private insurance
4) Help the safety net for the uninsured

Much more needs to be done, and we can and must do that over the next couple years with studies, experiments, and most importantly by using the power of markets and Kansas values.

EXECUTIVE SUMMARY HOUSE BILL NO. 2591 Foundations of Health Reform Act of 2007

By Committee on Appropriations

There are several sections in the bill that encourage the beginnings of significant Health Reform and sets the stage for much larger reforms.

Sections 1-11 Medicaid Reform

Authorizes KHPA to begin to seek and implement Medicaid changes through waivers and plan amendments and gives legislative backing and inpur to KPHA to modernize Medicaid by 2013. Most of this has already been encouraged by the federal government in the Deficit Reduction Act and approved by CMS in other states including FL, OK, SC, GA, and others.

It suggests waivers for: 1)Long- term care system, 2) state children's health insurance program, 3 general medicaid system, 4 waste, fraud and abuse 5) block grant multi-year waiver if deemed feasible 6)strengthen recovery payments 7)use tax credits and vouchers, 8) wellness, obesity and smoking programs, and 9) uninsured funding programs.

It authorizes a demonstration program which if successful could be expanded by 2013. It would provide medicaid consumers multiple health care plans and HSA's, a Health Earned Income Tax Credit, long term care options, introduce competition and market forces as major factors that lower cost, design insurance policies which are portable and renewable once a recipient leaves Medicaid.

It empowers KPHA to use a form of premium assistance which allows access to access commercial health insurance policies and employer sponsored plans and plans offered through a Kansas Health Exchange.

It would empower KPHA to develop a health opportunity accounts used by the recipient to defray health-care related costs including copayments, noncovered benefits, wellness initiatives and future health insurance once a health opportunity account holder leaves Medicaid. Account holder shall receive rewards for making healthy lifestyle choices; such as: Quitting smoking, losing excess weight, etc.

The bill authorizes KPHA to extend its electronic medical records initiatives for providers and demonstrates an electronic prescribing pilot program.

It authorizes KPHA to develop plan for long-term care that includes community-based and nursing home options, marketbased and quality measured pricing, opportunity accounts and counseling, incentives for LTC planning

It authorizes KHPA to continue to develop a program to encourage primary care services in lieu of emergency room utilization and reduce billing and payment errors. Stakeholders would study methods to rationalize charges for self-pay patients.

LONGTERM CARE SECTION 12-16

This would create language for individuals who buy long-term care policies to protect their assets once their policies are exhausted and access Medicaid. It would reward responsible behavior for those who buy LTC insurance.

POLICIES TO ENCOURAGE MORE PROVIDERS OF CARE FOR UNINSURED SECTION 17

Utah has enacted similar legislation. This recognizes that heavy liability exposure limits number of providers of charity care. It would encourage the provision of free health care in exchange for a limitation on liability for the health care facilities and providers. There would still be significant liability for providers. Written agreement by the patient and the provider would be necessary.

SECTIONS 18-20 BEGIN AND STUDY PRIVATE INSURANCE EXCHANGE SIMILAR TO UNINSURABLE POOL

This creates nonprofit Kansas insurance exchange association organized the same as the Uninsurable Pool. Its purpose is providing Kansans with greater access, choice, renewability and portability of health insurance and long-term care insurance. It would recommend a way to organize and implement such a program that would allow pooling of public/private payments for insurance. It would eventually have a website that would list multiple plans of all who wish to participate like we see with Medicare prescription plans.

It could eventually explore methods to cut bureaucracy for patients, insurers, and providers, determine methods to include medicaid options through the exchange, and develop procedures for insurance brokers and insurance agents to use the exchange.

SMALL EMPLOYER CAFETERIA PLAN DEVELOPMENT PROGRAM SECTIONS 21

This would authorize the Department of Commerce to create a two year program for rural and small businesses to implement cafeteria plans.

POLICY CHANGES TO ENCOURAGE CONVERAGE AND COMPETITION AND FACILITATE MEDICAID WAIVERS SECTIONS 27-35

Multiple pages from previous law repeated. The operative language is to extend state Cobra for less than 25 employees from 6 to 18 months. Insurers that participate in the Exchange can go to "file and use" rather than waiting 30 days before implementing. For purposes of obtaining federal waivers under Section1115 State Employees Health Plan is expanded to include 2 additional plans: a) federal basic Medicaid benefits plan and b) $1250 adult or $800 child cash payment in lieu of state insurance provided they have proof of insurance

Requested KHPA language to allow premium assistance and expands Medicaid coverage to include adult family members. This is a phased-in premium assistance plan to assist eligible low income Kansas residents with the purchase of private insurance or other benefits that are actuarially equivalent to the Kansas state employee health plan. In program years one and two, subject to other eligibility requirements, eligible participants will consist of families at and under 50% of the federal poverty level. Subject to appropriation of funds and other eligibility requirements, eligible participants in program year three will consist of families at and under 75% of the federal poverty level. Subject to appropriation of funds and other eligibility requirements, eligible participants in program year four will consist of families at an under 100% of the federal poverty level.

AMENDMENT

This would allow creation or use of current foundation for healthcare. It would allow funds from one time windfalls, non-profit sales, and asset sales and premium taxes from some insurance programs to be held in the foundation. The proceeds would come back to SGF as an endowment for future use.

It includes: a) marketing program to promote Section 125 plans, b) encourage providers of cafeteria plans to target small and rural businesses, c) develop incentives for small businesses to implement cafeteria plans.

ASSOCIATION PLAN DEVELOPMENT SECTION 22

Secretary of commerce authorized to make grants or no interest loans for the purpose of financing the initial costs to form health associations such as Hispanic or business groups. Loans would be interest free, leveraged with other matching funds, and must have recourse. Initially $250,000 would be available.

SECTIONS 23-24 LIMITED AUTHORITY FOR INSURANCE COMMISSIONER TO WAIVE REGULATIONS TO INCREASE ACCESS AND AFFORDABILITY

Gives Insurance Commissioner power to waive rules, regs or authorities to A)maintain affordable individual and group rates or B) target groups or areas with high uninsured rates. Insurance Commissioner may explore regional insurance pools.

STUDIES AND INTERIMS COMPATIBLE WITH SB 309 AND HR 6015 SECTIONS 25-26

By November 1, 2007, KHPA to deliver health reform options and draft legislation. They would analyze policies that are designed to increase portability, to increase individual ownership of health care policies, to utilize pre-tax dollars for the purchase of health insurance, and to expand consumer responsibility for making health care decisions. KHPA in conjunction with JHPOC shall obtain economic and actuarial analyses, examine reinsurance and premium volatility.

In performing the tasks, KHPA shall consider vision statement of HR6015

There could be possible interims on: (a) Increase number of commercially insured Kansans; (b) improve competitiveness in the insurance industry; (c) examine laws and regulations governing the types of plans available to Kansans and their effect on affordability, accessibility, renewability and portability of such policies; (d) study the role of short term gap insurance; (e) study transparency and actual market pricing of health services; (f) examine the data requirements KHPA and other departments; (g) examine if the uninsurable pool needs to be modified; (h) examine pooling arrangements and other requirements to encourage affordability;(i) examine role of secondary insurance and other changes for long-term stability; (j) consider methods to increase the number of Kansans with long-term care insurance.

Amendment
KansasHealthFund#1

New Sec. 28. (a) There is hereby established the Kansas health permanent fund which shall not be part of the state treasury. The Kansas health permanent fund shall constitute a trust fund and shall be invested, managed and administered by a foundation designated in accordance with the provisions of this section.

(b) In accordance with this section, the foundation to invest, manage and administer the Kansas health permanent fund shall be designated by the state finance council acting on this matter which is hereby characterized as a matter of legislative delegation and subject to the guidelines prescribed in subsection (c) of K.S.A. 75-3711c, and amendments thereto, except that such approval also may be given while the legislature is in session. The foundation shall be selected from the following: (1) The Sunflower Foundation, (2) the Kansas Health Foundation, or (3) another not-for-profit foundation. The foundation selected shall enter into one or more agreements with the Kansas health policy authority which shall set forth the powers, duties and functions of the foundation with respect to the Kansas health permanent fund. In the case of pre-existing foundations, selection criteria shall include the amount of additional financing that will be provided for health care programs under this act if selected.

(c) The foundation selected in accordance with this section shall invest or provide for the investment of the Kansas health permanent fund and shall manage and administer the Kansas health permanent fund in accordance with the provisions of rules and regulations of the Kansas health policy authority and the provisions of Kansas statutes.

(d) The foundation shall establish and maintain accounts within the Kansas health permanent fund, for health and health care programs for children, for health and health care programs for other

individuals, long-term care programs for seniors, for moneys dedicated for the state matching requirements, and for such other purposes as may be prescribed by statute or by the Kansas health policy authority as authorized by statute. In addition to such accounts, the foundation may establish and maintain separate trust funds as may be prescribed by the Kansas health policy authority as authorized by statute.

(e) Of the moneys received during the state fiscal years ending June 30, 2008, June 30, 2009, June 30, 2010, June 30, 2011, and June 30, 2012, by the state of Kansas pursuant to the tobacco litigation settlement agreements entered into by the attorney general on behalf of the state of Kansas that are amounts allocated to Kansas from the strategic contribution fund established under the master settlement agreement, the first $10,000,000 in each such fiscal year shall be paid from the Kansas health care reserve fund to the Kansas health permanent fund.

(f) All interest and other investment proceeds by the investment of the moneys in the Kansas health permanent fund shall be credited to the Kansas health permanent fund.

(g) All moneys received by the foundation for the Kansas health permanent fund from the Kansas health policy authority, commissioner of insurance, or any other state agency as provided by statute, or from the federal government, any other public agency or any private entity or other source shall be deposited in the Kansas health permanent fund, unless otherwise provided by law.

(h) Notwithstanding the provisions of any other statute, prior to the sale or other disposition or conveyance of any health-related hospitals, institutions or other health-related buildings or facilities that are owned by the state or any not-for-profit, charitable corporation or foundation, (1) such property and the proposed sale, disposition or conveyance shall be reviewed and evaluated with financial advisory services provided by a qualified investment institution or major merchant bank with significant experience with mergers and acquisitions involving more than $1,000,000,000, and

(2) the net proceeds of any such sale or other disposition or conveyance shall be paid to the Kansas health permanent fund.

(i) As provided by statute, the increase of revenues from each of the following sources that is attributable to insurance premium tax revenues received on new insurance policies or long-term care agreements entered into on or after the effective date of this act, other than any such increase attributable to increases in premium tax rates shall be paid to the Kansas health permanent fund.

Sec. 29. K.S.A. 38-2101 is hereby amended to read as follows: 38-2101. (a) There is hereby established in the state treasury the Kansas endowment for youth fund which shall constitute a trust fund and shall be invested, managed and administered in accordance with the provisions of this act by the board of trustees of the Kansas public employees retirement system established by K.S.A. 74-4905 and amendments thereto.

(b) Except as provided in section , and amendments thereto, all of the moneys received by the state pursuant to the tobacco litigation settlement agreements entered into by the attorney general on behalf of the state of Kansas, or pursuant to any judgment rendered, regarding the litigation against tobacco industry companies and related entities, shall be deposited in the state treasury and credited to the Kansas endowment for youth fund. All such moneys shall constitute an endowment which shall remain credited to the Kansas endowment for youth fund except as provided in this section or in K.S.A. 38-2102, and amendments thereto, for transfers to the children's initiatives fund. Expenditures may be made from the Kansas endowment for youth fund for the payment of the operating expenses of the Kansas children's cabinet and the board of trustees, including the expenses of investing and managing the moneys, which are attributable to the Kansas endowment for youth fund. All moneys credited to the Kansas endowment for youth fund shall be invested to provide an ongoing source of investment earnings available for periodic transfer to the

children's initiatives fund in accordance with this act. All expenditures from the Kansas endowment for youth fund shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the chairperson of the board of trustees of the Kansas public employees retirement system or by the chairperson's designee.

(c) On the effective date of this act, the director of accounts and reports shall transfer all moneys credited to the children's health care programs fund to the Kansas endowment for youth fund and the children's health care programs fund is hereby abolished. On and after July 1, 1999, whenever the children's health care programs fund, or words of like effect, is referred to or designated by statute, contract or other document, such reference or designation shall be deemed to apply to the Kansas endowment for youth fund.

PROPOSED AMENDMENTS
22 MARCH 2007

Session of 2007

HOUSE BILL No. 2591

By Committee on Appropriations

3-21

AN ACT enacting the foundations of health reform act of 2007; amending K.S.A. 39-785 and 40-2215 and K.S.A. 2006 Supp. 39-709, 40-19c06, 40-2209, 40-3209, 75-6501 and 75-7408 and repealing the existing sections; also repealing K.S.A. 2006 Supp. 39-709d.

[38-2101 and

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

New Section 1. Sections 1 through [11] of this act shall be known and may be cited as the Kansas medicaid reform act of 2007.

[12

New Sec. 2. The health policy oversight committee and the Kansas health policy authority shall work together to write state plan amendments and waivers to implement the Kansas medicaid reform act of 2007. The Kansas health policy authority shall request the federal centers for medicare and medicaid to appoint a special representative to work with the health policy authority to expedite, coordinate and implement the changes to the medicaid program in Kansas and to request additional transition funds.

New Sec. 3. (a) The Kansas health policy authority is authorized to seek waivers or other federal authorizations, or both, to create a statewide program to provide for a more efficient and effective service delivery system that enhances quality of care and client outcomes in the Kansas medicaid program.

(b) The Kansas health policy authority shall develop and submit for approval, applications for waivers of applicable federal laws and regulations as necessary to implement the provisions of the Kansas medicaid reform act of 2007. Copies of all waivers submitted to and approved by the United States centers for medicare and medicaid services under this section shall be provided to the joint committee on health policy oversight prior to submission and within 10 days of their approval. The Kansas health policy authority shall submit a plan containing a recommended timeline for implementation of any waivers and budgetary projections of the effect of the Kansas medicaid reform act of 2007. This implementation plan shall be submitted to the governor, the speaker of the house of representatives, the president of the senate and the joint committee on health policy oversight.

(1) After consultation with the proper legislative and executive

House Social Service Budget Committee
Date 3-22-07
Attachment # 6

House Social Service Budget
3-22-2007
Attachment 6

(5) that the legislature, agencies of the executive branch of state government and the private sector are urged to collaborate to strengthen safety net clinics and emergency rooms and encourage more providers to expand charity care; and

(6) that long term stability of state financial support for the health care and insurance system be improved through a private foundation or trust fund into which one time windfalls, asset sales, public and private grants and other revenues are paid and the earnings on such revenues be available to the state to invest in health initiatives listed above.

New Sec. 26. The speaker of the house of representatives may appoint an interim committee or committees to examine policy changes to:

(a) Increase number of commercially insured Kansans;

(b) improve competitiveness in the insurance industry to improve affordability and accessibility for Kansas consumers;

(c) examine laws and regulations governing the types of plans available to Kansans and their effect on affordability, accessibility, renewability and portability of such policies;

(d) study the role of short term gap insurance for those in transition between jobs;

(e) study transparency and methods to have actual market pricing of health services and how to eliminate confusing fee schedules;

(f) examine the data requirements on the health industry made by the department of health and environment, the commissioner of insurance and the Kansas health policy authority;

(g) examine if the uninsurable pool needs to be modified;

(h) examine pooling arrangements and other requirements to encourage affordability;

(i) examine role of secondary insurance and other changes for long-term stability;

(j) consider methods to increase the number of Kansans with long-term care insurance; and

(k) related issues as determined by the speaker.

Insert attached sections 27 + 28;
renumbering sections accordingly;
updating internal cross-references
accordingly

Sec. 27. K.S.A. 2006 Supp. 39-709 is hereby amended to read as follows: 39-709. (a) *General eligibility requirements for assistance for which federal moneys are expended.* Subject to the additional requirements below, assistance in accordance with plans under which federal moneys are expended may be granted to any needy person who:

(1) Has insufficient income or resources to provide a reasonable subsistence compatible with decency and health. Where a husband and wife are living together, the combined income or resources of both shall be considered in determining the eligibility of either or both for such assistance unless otherwise prohibited by law. The secretary, in determining need of any applicant for or recipient of assistance shall not take into

ticipants in program year three will consist of families at and under 75% of the federal poverty level. Subject to appropriation of funds and other eligibility requirements, eligible participants in program year four will consist of families at an under 100% of the federal poverty level. The Kansas health policy authority is authorized to seek any approval from the centers for medicare and medicaid services necessary to accomplish the development or expansion of premium assistance programs;

(2) the restrictive drug formulary, the drug utilization review program, including oversight of the medicaid drug utilization review board, and the electronic claims management system as provided in K.S.A. 39-7,116 through 39-7,121 and K.S.A. 2006 Supp. 39-7,121a through 39-7,121e, and amendments thereto; and

(3) administering any other health programs delegated to the Kansas health policy authority by the governor or by a contract with another state agency.

(b) Except to the extent required by its single state agency role as designated in K.S.A. 2006 Supp. 75-7409, and amendments thereto, or as otherwise provided pursuant to this act the Kansas health policy authority shall not be responsible for health care planning, administration, purchasing and data with respect to the following:

(1) The mental health reform act, K.S.A. 39-1601 et seq., and amendments thereto;

(2) the developmental disabilities reform act, K.S.A. 39-1801 et seq., and amendments thereto;

(3) the mental health program of the state of Kansas as prescribed under K.S.A. 75-3304a, and amendments thereto;

(4) the addiction and prevention services prescribed under K.S.A. 65-4001 et seq., and amendments thereto; or

(5) any institution, as defined in K.S.A. 76-12a01, and amendments thereto.

Sec. 35. K.S.A. 39-785 and 40-2215 and K.S.A. 2006 Supp. 39-709, 39-709d, 40-19c06, 40-2209, 40-3209, 75-6501 and 75-7408 are hereby repealed.

38-2101 and

Sec. 36. This act shall take effect and be in force from and after its publication in the Kansas register.

New Sec. 27. (a) There is hereby established the Kansas health permanent fund which shall not be part of the state treasury. The Kansas health permanent fund shall constitute a trust fund and shall be invested, managed and administered by a foundation designated in accordance with the provisions of this section.

(b) In accordance with this section, the foundation to invest, manage and administer the Kansas health permanent fund shall be designated by the state finance council acting on this matter which is hereby characterized as a matter of legislative delegation and subject to the guidelines prescribed in subsection (c) of K.S.A. 75-3711c, and amendments thereto, except that such approval also may be given while the legislature is in session. The foundation shall be selected from the following: (1) The Sunflower Foundation, (2) the Kansas Health Foundation, or (3) another not-for-profit foundation. The foundation selected shall enter into one or more agreements with the Kansas health policy authority which shall set forth the powers, duties and functions of the foundation with respect to the Kansas health permanent fund. In the case of pre-existing foundations, selection criteria shall include the amount of additional financing that will be provided for health care programs under this act if selected.

(c) The foundation selected in accordance with this section shall invest or provide for the investment of the Kansas health permanent fund and shall manage and administer the Kansas health permanent fund in accordance with the provisions of rules and regulations of the Kansas health policy authority and the provisions of Kansas statutes.

(d) The foundation shall establish and maintain accounts within the Kansas health permanent fund, for health and health care programs for children, for health and health care programs for other individuals, long-term care programs for seniors, for moneys dedicated for the state matching requirements, and for such other purposes as may be prescribed by statute or by the Kansas health policy authority as authorized by statute. In

addition to such accounts, the foundation may establish and maintain separate trust funds as may be prescribed by the Kansas health policy authority as authorized by statute.

(e) Of the moneys received during the state fiscal years ending June 30, 2008, June 30, 2009, June 30, 2010, June 30, 2011, and June 30, 2012, by the state of Kansas pursuant to the tobacco litigation settlement agreements entered into by the attorney general on behalf of the state of Kansas that are amounts allocated to Kansas from the strategic contribution fund established under the master settlement agreement, the first $10,000,000 in each such fiscal year shall be paid from the Kansas health care reserve fund to the Kansas health permanent fund.

(f) All interest and other investment proceeds by the investment of the moneys in the Kansas health permanent fund shall be credited to the Kansas health permanent fund.

(g) All moneys received by the foundation for the Kansas health permanent fund from the Kansas health policy authority, commissioner of insurance, or any other state agency as provided by statute, or from the federal government, any other public agency or any private entity or other source shall be deposited in the Kansas health permanent fund, unless otherwise provided by law.

(h) Notwithstanding the provisions of any other statute, prior to the sale or other disposition or conveyance of any health-related hospitals, institutions or other health-related buildings or facilities that are owned by the state or any not-for-profit, charitable corporation or foundation, (1) such property and the proposed sale, disposition or conveyance shall be reviewed and evaluated with financial advisory services provided by a qualified investment institution or major merchant bank with significant experience with mergers and acquisitions involving more than $1,000,000,000, and (2) the net proceeds of any such sale or other disposition or conveyance shall be paid to the Kansas health permanent fund.

(i) As provided by statute, the increase of revenues from each of the following sources that is attributable to insurance

premium tax revenues received on new insurance policies o- long-term care agreements entered into on or after the effective date of this act, other than any such increase attributable to increases in premium tax rates shall be paid to the Kansas health permanent fund.

Sec. 28. K.S.A. 38-2101 is hereby amended to read as follows: 38-2101. (a) There is hereby established in the state treasury the Kansas endowment for youth fund which shall constitute a trust fund and shall be invested, managed and administered in accordance with the provisions of this act by the board of trustees of the Kansas public employees retirement system established by K.S.A. 74-4905 and amendments thereto.

(b) Except as provided in section 27, and amendments thereto, all of the moneys received by the state pursuant to the tobacco litigation settlement agreements entered into by the attorney general on behalf of the state of Kansas, or pursuant to any judgment rendered, regarding the litigation against tobacco industry companies and related entities, shall be deposited in the state treasury and credited to the Kansas endowment for youth fund. All such moneys shall constitute an endowment which shall remain credited to the Kansas endowment for youth fund except as provided in this section or in K.S.A. 38-2102, and amendments thereto, for transfers to the children's initiatives fund. Expenditures may be made from the Kansas endowment for youth fund for the payment of the operating expenses of the Kansas children's cabinet and the board of trustees, including the expenses of investing and managing the moneys, which are attributable to the Kansas endowment for youth fund. All moneys credited to the Kansas endowment for youth fund shall be invested to provide an ongoing source of investment earnings available for periodic transfer to the children's initiatives fund in accordance with this act. All expenditures from the Kansas endowment for youth fund shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the chairperson of the board of trustees of the Kansas public employees retirement system or by the chairperson's designee.

(c) On the effective date of this act, the director of accounts and reports shall transfer all moneys credited to the children's health care programs fund to the Kansas endowment for youth fund and the children's health care programs fund is hereby abolished. On and after July 1, 1999, whenever the children's health care programs fund, or words of like effect, is referred to or designated by statute, contract or other document, such reference or designation shall be deemed to apply to the Kansas endowment for youth fund.

Testimony of Greg Schneider, Flint Hills Center for Public Policy

March 22, 2007

Madam Chairwoman and Members of the Committee,

My name is Gregory L. Schneider and I am a senior fellow with the Flint Hills Center for Public Policy, an independent public policy institute, based in Wichita, Kansas. For the past year I have directed the Flint Hills Center's Consumer-Driven Health Care Project. I am also a historian and teach at Emporia State University. As a historian of 20th century American politics, I teach and write about the development of the welfare state and also about those who urge restraint in the growth of state power. The development of health care is one aspect of the larger growth of government spending over the past seventy years and has been an interest of mine for some time. My work at Flint Hills compliments my job as a professor: I help educate Kansans on the need for reform of entitlements like Medicaid before they contribute to the ruin of state budgets.

Over the past three years, the Flint Hills Center has been a leader in the state in studying the fiscal and budgetary implications of the continued growth and enrollment of more Kansans on Medicaid, both the acute and long-term care sides of Medicaid's delivery system. In the *Medicaid Handbook* and in our latest publication, *The Medicaid Digest,* Flint Hills policy scholars—experts from both Kansas and outside Kansas—have been arguing that the current Medicaid system is unsustainable and that its further growth will contribute to fiscal dilemmas for the state. Budget priorities like education and other needs will be

threatened by the growth of health care costs. It is imperative that the state get control of the exorbitant costs in both Medicaid's acute and long-term care delivery systems. The Flint Hills Center has continually urged consumer-driven reforms to shift people away from Medicaid while preserving the Medicaid program for whom it was intended: the truly poor and needy.

Medicaid was founded as a welfare program but it has expanded beyond its original intentions, for instance, to protect the assets of middle-class and upper-class Americans through its payment of LTC. Increasingly, and alarmingly, Medicaid is looked at to solve the problem of all uninsured Americans. The argument used by some is that we need to cover more of the uninsured via Medicaid. This was Governor Sebelius' proposal last fall regarding the expansion of the SCHIP program to cover all uninsured children in the state. Medicaid has grown tremendously in the last ten years in Kansas and further enrollment increases would break the state's budget.

At the end of 2006 Kansas had close to 300,000 individuals receiving Medicaid services—that number is up from 200,000 in the late 1990s and from around 150,000 in 1995. The costs of increasing Medicaid roles will contribute to fiscal dilemmas: i.e. if we pay more for state-funded health care, we are forced to raise taxes or cut services elsewhere, like in education. The choices are politically unpalatable and leave lawmakers with one only option: reform Medicaid.

Flint Hills advocates that individuals are able to control and to make their own personal decisions involving their own lives and their own health care. We

favor what Kansas Medical Society President Richard Warner has called personalized medicine, reestablishing the doctor-patient relationship and reestablishing a payment structure which will make this relationship the most important one when it comes to medicine. We want to empower individuals to take control over their health care decisions.

We do not call for an end to Medicaid; we call for its preservation as a welfare program whose population—the truly needy and poor—will continue to be served by Medicaid until better options are available for those constituents. Moving more individuals from Medicaid roles and towards independence from government-managed care will contribute to greater individual freedom and a more efficient and effective use of health care resources.

As such, I would like to speak in favor of House Bill 2591, the Kansas Medicaid Reform Act of 2007. This bill, as proposed, is the most comprehensive reform of Medicaid among several proposals in the legislature this year. It contains several features which Flint Hills endorses, including:

a) waivers to CMS to evaluate the state's Medicaid system, investigate fraud and abuse of the program; waivers for block grants, tax credits and vouchers; and a waiver for wellness programs and a waiver for Medicaid uninsured studies;

b) the introduction of competition and market forces as major factors to lower the cost of care;

c) the creation of health opportunity accounts to move Medicaid recipients to private health insurance; contributions to such accounts to reward

responsible health care choices; and the ability to use such monies to purchase Health Savings Accounts or other insurance products to move off government assistance;

d) The establishment of long-term care opportunity accounts for Medicaid LTC recipients. We also applaud the incentives in the bill designed to encourage more personal responsibility for LTC planning, including the purchase of LTC insurance and the continued use of tax incentives to do so;

The most innovative and important part of the bill concerns the establishment of a nonprofit Kansas Insurance Exchange Association (Section 19). Michael Bond, an adjunct fellow with Flint Hills, testified before this committee last week concerning such an exchange and the *Wichita Eagle* published his opinion editorial on the exchange on Tuesday, March 20, 2007. Flint Hills has just released the wider study "Dealing With Kansas' Uninsured" available on our website at www.flinthills.org. We think the insurance exchange—not a connector—but a privately run entity to provide insurance choice, access and portability to citizens of the state outside of mandates and government regulations, is an important development and one which will contribute to a lowering of the number of uninsured in the state without the burden of added government spending.

We strongly support the creative and thorough effort in HB 2591 to harness market forces to solve the health care problems. This bill represents the type of visionary, comprehensive approach to health care reform which could

make Kansas the leader among state reform efforts in providing affordable and portable insurance to all its citizens without burdening tax payers or forcing cuts in services elsewhere in the state budget. It also will maintain the fiscal health of the state, preserving limited state resources for the truly needy and focusing on moving those same individuals eventually to independence and responsibility for their own care.

On March 21, 2007 an editorial in the *Wichita Eagle* lamented the lack of action on health care reform this session. The editors would amend that view now, I think, after seeing the comprehensive nature of the plan offered in this bill. The Flint Hills Center supports HB 2591 as the foundational approach needed to begin the long-term push towards health care reform and towards consumer-driven care. We favor its passage and enactment into law. Thank you for your time and attention.

KAMU

Kansas Association
for the
Medically Underserved
The State Primary Care Association

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Testimony on:
HB 2591 – Health Reform Act of 2007

Presented to:
House Social Services Budget Committee

By:
Karla Finnell
Executive Director
Kansas Association for the Medically Underserved

March 22, 2007

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House Social Services Budget Committee
March 22, 2007

My name is Karla Finnell. I am the executive director of the Kansas Association for the Medically Underserved.

Today, I'm speaking to you in the professional capacity as the executive director of KAMU and also from my personal experience. I was raised in a rural area of Oklahoma by parents who grew up during the Depression. My father left school in the 8th grade to work. Our family was supported by his employment at multiple jobs; most of which did not include health insurance. My mother's significant health problems – a serious heart attack followed by kidney failure – led me to know first-hand the effects of not having adequate insurance, which includes difficulty obtaining care, the worsening of health caused by delaying care to avoid financial strain on the family, and finally the financial burdens of receiving care.

This scenario repeats itself today for families across the nation, creating an ever-pressing health care crisis. Expanding coverage to adults is important to maintain and protect the family structure for children.

I obtained degrees in business administration and a jurist doctorate, followed by a master's in public health and policy. As a lawyer, I oversaw bankruptcy reorganizations of family farms. I observed the impact of the cost of health insurance on restructuring a family livelihood with irregular income, as well as rural attitudes about and experiences with health care. When choosing between needs for farm and other basic needs such as repair to vehicles, health care is usually the loser.

Throughout my career in public health, I have observed the health care crisis worsening, as well as the difficulty of aligning payment mechanisms to promote more effective health care. We all know that many initiatives have only had a short-term impact on reducing health care costs and have not always improved quality. That being said, many health care issues continue to call for reform.

KAMU applauds Representative Colyer for his passion and commitment to this crisis, and his leadership in addressing the intractable problems of health care delivery by introducing HB 2591. As we address health care reform in Kansas, I encourage stakeholders and advocates to seek compromise to obtain the most effective reforms for the most people. HB 2591 proposes comprehensive health care reform. In the brevity of time we've had to review this bill, we comment on a few of the concepts.

- **Programs for the Uninsured:** KAMU supports the concept of funding programs for the uninsured. In St. Louis, Missouri, a program was implemented utilizing a limited portion of disproportionate share hospital funds to enable the St. Louis region to transition its "safety net" system of care for the medically indigent to a viable, self-sustaining model. Research indicates that the project was successful in meeting its goal. A comprehensive report can be found at http://dss.mo.gov/dms/mc/pdf/eval_1115_02-03.pdf. This model was conducted in an urban setting and the applicability to rural areas would need to be evaluated. Such a waiver would clearly need to be a win/win solution that would support

maintenance of our hospital systems in rural and urban areas, and hopefully support the allocation of additional disproportionate share dollars to Kansas. Attached is a map of disproportionate share hospitals in Kansas in relation to physical proximity to a safety net clinic.

- **Use of Technology:** We have technology options now that have not been as available in the past. In this regard, KAMU supports the use of technology to identify patients who are at high risk and its use as an effective means of managing the condition and providing patient education. A pilot has been implemented in Sedgwick County. A similar model in Indiana employs technology, telephone management, and human resources. In that model, patients identified as high risk or high users of the system are supported by telephone case management. Those in the upper percentile of use are also supported by nurse managers who work with the provider and the patient to develop a care management plan. This plan is developed after home visits and in consultation with the patient. The nurse continues to manage the case for six months and then the patient is transferred to the telephonic case management system.

- **Incentive-Based Systems:** Other options include financial rewards to physicians and primary care safety net providers, including community health centers, who use a chronic care feedback model that collects and manages data on patients' medicines, vital signs, lab results, goals and educational needs. This model is called the "Health Disparities Collaborative" in community health centers and has proven extremely effective at improving the health of Kansans, as well as reducing avoidable hospitalizations.

  When employing prevention and wellness programs, debit cards, health savings accounts and other strategies to align use of health care with rewards for healthy behavior, we must be ever mindful that individuals with low financial resources are not a homogenous populations. We need to carefully create incentives that ensure that access to needed care is maintained.

- **Maintain Cost-based Reimbursement:** Community health centers or FQHCs receive cost-based reimbursement or prospective payment reimbursement to ensure that while serving Medicaid patients that grant dollars are not redirected to support uncompensated care for Medicaid or other waiver beneficiaries. We would ask that this principle be maintained to ensure a strong and viable safety net clinic system.

- **Sustain Effective Programs for Native American Populations:** KAMU supports systems to ensure that implementation of this act does not negatively affect the ability of American Indian or Alaska native beneficiaries to access services at Indian Health Service facilities, tribally operated health facilities and urban Indian health programs. Hunter Health Clinic in Wichita, Kansas, is such an Indian Health Service facility. Maintenance and improvement of these systems will be important for this clinic that provides services to 17,928 Kansans,

including 13,424 uninsured, with special emphasis on Native Americans and homeless populations.

- **Charitable Health Care Facilities:** Kansas has had a Charitable Health Care Provider Act in place since 1991. Currently, it is our understanding that nearly 4,000 providers are registered to provide charitable health care. Under the Kansas law, awards and damages are limited to $500,000.00, but a plaintiff may bring a cause of action for negligence, intentional wrongdoing, and gross negligence. HB 2591 does not limit the amount of the award but limits the types of causes of actions and the covered settings. To our knowledge, subject to a few changes, the existing Charitable Health Care Provider Act is working. One change we do seek, however, is adding a broader range of behavioral professionals to the list of covered providers in the statute. The second change would be a regulatory change clarifying that an FQHC Look-Alike is a covered entity.

As further details are developed, KAMU would be willing to support the organization of focus groups to evaluate the plausibility of proposals from the patient perspective. Thank you.

KANSAS FARM BUREAU
The Voice of Agriculture

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PUBLIC POLICY STATEMENT

HOUSE SOCIAL SERVICES BUDGET COMMITTEE

RE: HB 2591; Foundations of Health Reform Act of 2007

March 22, 2007
Topeka, Kansas

Testimony Presented by:
Terry D. Holdren
National Director
KFB Governmental Relations

Chairman Bethel and members of the House Committee on Social Service Budget, thank you for the opportunity to appear today. I am Terry Holdren, National Director of Government Relations for Kansas Farm Bureau. KFB is the state's largest general farm organization representing more than 40,000 farm and ranch families through our 105 county Farm Bureau Associations.

Our members are independent business men and women. They purchase health insurance in the private market and regularly voice their concern about the high cost of insurance products and health care services. On our most recent KFB Governor's Tour in Smith County one of the hosts made the observation that for her family, health care consumes over 17% of their budget—more than any other item! This is simply not acceptable—we must act now to begin rolling back these high costs!

KFB supports rational, market based solutions that will provide options and enhance convenience for Kansas citizens. It will provide immediate help for our members and others who are currently not able to pool their risk in an association or limit their cost by shopping for alternatives to traditional insurance products.

Thank you for the opportunity to share the views of our membership. We realize that time is short and would respectfully ask that you move rapidly to find workable solutions for Kansas citizens.

INSIGHT
For the week of March 19, 2007

High-quality, affordable health care

By John Schlageck, Kansas Farm Bureau

All Kansans should have access to high quality health care. People of our state have heard this refrain for decades and each year it comes up in the Kansas legislature.

This session is no different. Recently, members of the Kansas House Republican task force on health care unveiled their plan to help more Kansans get the medical coverage they need.

Task force members have developed *KanCare.* This is a four-part health care plan that uses market forces to expand coverage, limit costs, improve quality and guarantee long-term stability for all Kansans, according to the members.

The first key to the task-force plan involves making commercial insurance more affordable. Allowing consumers to use pre-tax dollars to pay for health care will do this. It also calls for expanding the commercial market and encouraging more insurers and plans which will hold costs through competition.

The second key will help the uninsured or those on Medicaid find stable health insurance. Examples include individuals between jobs who are without insurance. They can use vouchers/tax credits to keep insurance. It will also provide seed money to encourage association plans targeted to small communities, business groups and ethnic organizations. Also, children with Medicaid can be placed on their parent's family plan with vouchers or credits.

Medicaid reform, the new *MediKan* is the third key of the House Republican task force plan. The main goal here is to preserve and stabilize a safety net.

This is designed to work with the federal government for new programs to eliminate waste and fraud, help seniors get more home health care rather than nursing homes, and provide wellness initiatives. *MediKan* will expand choices for doctors and health plans and gives the state more options in case contractors have problems.

This third key will also give patients a choice from many benefit packages with some for specially designed needs. Another option is to use consumer-driven health plans. With these, Medicaid recipients get a health opportunity account. The state puts money into a patient to use for co-pays, glasses, weight-loss programs, etc.

Strengthening charity care for a smaller pool of uninsured is the fourth key to the House plan. This is designed to reduce the number of uninsured, strengthen free-care clinics and create incentives for providers to give more free care.

Having rolled out this health care proposal this late in the 2007 session, it appears the chance of action on such a plan is 50/50 at best. It will probably be turned over to an interim committee and worked this summer.

No doubt this plan is a step in the right direction. It's consistent with what farmers, ranchers and independent business people would like to see in a state health care program.

This plan addresses challenges facing self-employed citizens who don't receive health care as a benefit, and are required to pay for such insurance out of their own pockets. That is expensive.

The proposed House plan is fairly convenient and is supposed to lower costs while providing several options. It is also portable, especially for those people who may be in a position of changing jobs without health care.

Finally it offers health saving's accounts which are a good component of any insurance plan. It's one plan that's been rolled out to help provide high-quality, affordable health care for Kansans. It deserves careful consideration and a good hard look.

John Schlageck has been writing about farming and ranching in Kansas for more than 25 years. He is the managing editor of "Kansas Living," a quarterly magazine dedicated to agriculture and rural life in Kansas.

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Kansas Health Policy Authority
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MARCIA J. NIELSEN, PhD, MPH
Executive Director

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Deputy Director

SCOTT BRUNNER
Chief Financial Officer

Kansas Health Policy Authority
Testimony

presented to:
House Social Services Budget Committee
March 22, 2007

by:
Dr. Marcia Nielsen
Executive Director

March 22, 2007

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Testimony on House Bill 2591

Thank you, Mr. Chairman and members of the Committee. I am Marcia Nielsen, Executive Director of the Kansas Health Policy Authority. I would like to briefly share with the committee my perspective and concerns about HB 2591. I would encourage you to oppose this legislation in its current form.

Although I am very pleased that significant attention is being paid to the importance of providing affordable access to health care in Kansas, I do not support this legislation in its existing form. Based on our rapid read of the bill, the legislation is surprisingly broad in nature and convoluted in approach. There are a number of moving parts with large implications for low income Kansans and to my knowledge there is very little impact analysis or cost information for the bill. Moreover, there is internal inconsistency between sections that make it difficult to understand the intent of the legislation. There are also a number of issues that the Center for Medicare and Medicaid Services (CMS) would find troubling and unlikely to approve. While this legislation does bring up some interesting and innovative ideas that I would be willing to explore in a collaborative fashion, this bill was not created in a collaborative process. I am unaware of stakeholder input into this legislation, and my agency has not been a participant in crafting it.

In providing this perspective, I believe it would be helpful if the committee were provided with some information about the Health for All Kansans Steering Committee that began meeting in early February of this year. Attached to this testimony are a number of documents that outline the charter given to the Steering Committee by the KHPA Board. As you will see, the steering committee included four legislators and several board members. Consensus was achieved on a short term package for this legislation session (attached) as well as a longer term road map to health reform for next year, which was embodied in the revised version of SB 309. The full KHPA voted to endorse both proposals at our Board meeting on Tuesday of this week. The short term legislative package was introduced in the Senate Ways and Means Committee and here in the Appropriations Committee yesterday.

I am proud of the collaborative process we developed, which were held in a series of public meetings and with significant feedback from the legislative leadership and the Governor's office. Our plan and timeline for broad health reform will be developed *this year* with the input from a wide array of stakeholders through the Advisory Councils recently adopted by the KHPA Board. All health policy options that will be developed will include an independent economic analysis in order to help legislators understand (a) the costs of any proposals (to the state, to the federal government, employers, and individuals) and (b) who will gain access to health insurance as a result of the policy option. This is the kind of information that policymakers need and deserve before advancing health reform plans for the state – Kansas specific policy requires Kansas specific information and input.

One example of the critical problems created by the bill is a requirement that the Kansas Health Policy Authority submit nine different waivers to CMS. However, there is no description of those waivers, what they are supposed to do, how they are supposed to work, and what the goals of each waiver would be. CMS waivers, as described in materials provided to you in your packet this afternoon, require a substantial amount of work to develop, implement, and evaluate. The State of Kansas provides services through Medicaid waivers to low income individuals who are frail and elderly, are victims of head injuries, have mental retardation/developmental disabilities, as well as physical disabilities. It is unclear how those waivered services fit into this legislation.
It is also unclear how the 15 – 40% of residents in long-term care facilities would currently "qualify" for long term care insurance.

I believe that the requirements of this legislation might cause one to question why the KHPA was created. We were given the mandate to coordinate health and health care for the state using data driven health policy. Although we are only in our ninth month of existence and have not yet been given the resources to adequately staff our agency, we have advanced a short term package of health reforms with our Board members and members of the legislature as a down payment on health reform this year. I ask that you continue to support the Kansas Health Policy Authority and give us an opportunity to do the job that you have asked us to do and oppose this legislation.

Thank you, I am happy to stand for questions.

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For immediate release:
March 5, 2007

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KHPA encouraged by House plan for health reform

The following is a statement by Marci Nielsen, PhD, MPH, Executive Director of the Kansas Health Policy Authority, in response to today's release of the Kansas House Republican Task Force on Health Care's plan for health reform:

"Over the past several months since the discussion of health reform began, I have been encouraged by the energy in both the Legislature and Governor's Office to truly accomplish health reform, and more importantly, provide access for all Kansans. Kansas has 300,000 residents who are without health insurance, and it is good news for the State that many legislators and stakeholders are following this process closely and want to be involved. With their support and input, we can reform the Kansas health system effectively.

"The Health for All Kansans Steering Committee met this afternoon and agreed on vision principles that will guide their work. These include increasing access to patient-centered care and services, integrating health promotion and education and disease prevention into these services, providing sustainable and affordable care, and reforming the system to be fiscally responsible and protect the health care safety net. During our meeting, we also discussed a legislative package that will be introduced this session with further discussion coming on March 13. The steps we take this session will be the framework for a larger health reform and access for all legislative package for the 2008 Kansas Legislature.

"As we agreed in the meeting today, the Kansas Health Policy Authority and its Board should take the lead on health reform and carefully and thoroughly review and oversee all options. We stand ready to work with the Governor, Legislature, and stakeholders to focus on common sense health reform that works for Kansas.

"Today, I was pleased with the leadership the Kansas House Republican Task Force has brought to the table. Their input and recommendations have been a critical piece in the Steering Committee. We look forward to working with them today and in the future as we seek to provide health access to all Kansans."

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Health for All Kansans Committee to seek accessible and affordable health care

First meeting of Steering Committee is Friday, Feb. 9

Earlier this week, the Kansas Health Policy Authority (KHPA) Board announced the formation of the Health for All Kansans Steering Committee. On Friday, February 9, the Committee will have its first meeting.

"This Committee is critical to the health reform process. They will seek specific ways to move toward the larger picture of health access for all," said Marcia Nielsen, PhD, MPH, Executive Director of Kansas Health Policy Authority. "I look forward to working alongside the other eleven members of the Committee as we seek workable solutions to barriers related to Kansans' health."

The Health for All Kansans Committee will take the lead in collaborating with the Governor, legislators, and interested parties in developing policies that will promote health and affordable health care. The first meeting will be at 1:30 p.m. on Friday, February 9, at Eisenhower State Office Building, 4th Floor, West Wing, Auditorium B, 701 SW Harrison, Topeka.

The Committee was formed at Governor Kathleen Sebelius' request to the board to form a task force to look at ways to address health access and affordability. Many state legislators also extended their interest in participating in such a task force.

"The fact that the Health Policy Authority has taken up this effort is very good news for Kansans," said Governor Sebelius. "By building a consensus of civic leaders, community members, and those in the health industry, we will craft a unified vision for bringing health care to every Kansan." Sebelius will speak to the committee at 1:30 p.m.

At this first meeting, the committee will discuss specific initiatives which will address these critical areas, assign legislative policy options to be developed by the KHPA Health Policy Team, and finally, schedule the next meeting, which will take place within the following three to four weeks.

###

Center for Medicare and Medicaid Services
Waiver Program Demonstration Projects

Research & Demonstration Projects - Section 1115

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. These projects are intended to demonstrate and evaluate a policy or approach has not been demonstrated on a widespread basis. Some states expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems.

There are two types of Medicaid authority that may be requested under Section 1115:

- Section 1115(a)(1) – allows the Secretary to waive provisions of section 1902 to operate demonstration programs, and
- Section 1115(a)(2) – allows the Secretary to provide Federal financial participation for costs that otherwise cannot be matched under Section 1903.

Projects are generally approved to operate for a five-year period, and states may submit renewal requests to continue the project for additional periods of time. Demonstrations must be "budget neutral" over the life of the project, meaning they cannot be expected to cost the Federal government more than it would cost without the waiver.

Application Process

There is no standardized format to apply for a Section 1115 demonstration, but the application must be submitted by the single state Medicaid agency. States often work collaboratively with CMS from the concept phase to further develop the proposal. A demonstration proposal typically discusses the environment, administration, eligibility, coverage and benefits, delivery system, access, quality, financing issues, systems support, implementation time frames, and evaluation and reporting.

Proposals are subject to the Centers for Medicare & Medicaid Services (CMS), Office of Management and Budget (OMB), and Department of Health and Human Services (HHS) approval, and may be subject to additional requirements such as site visits before implementation. CMS does not have a specific timeframe to approve, deny, or request additional information on the proposal. Additionally, CMS usually develops terms and conditions that outline the operation of the demonstration project when it is approved.

Managed Care/Freedom of Choice Waivers - Section 1915(b)

States may request Section 1915(b) waiver authority to operate programs that impact the delivery system of some or all of the individuals eligible for Medicaid in a state by

- mandatory enrollment of beneficiaries into managed care programs (although states have the option, through the Balanced Budget Act of 1997 to enroll certain beneficiaries into mandatory managed care via a State Plan Amendment), or
- creating a "carve out" delivery system for specialty care, such as behavioral health care.

Section 1915(b) waiver programs do not have to be operated statewide. They may not be used to expand eligibility to individuals not eligible under the approved Medicaid state plan. States also have the option to use savings achieved by using managed care to provide additional services to Medicaid beneficiaries not typically provided under the state plan.

To implement these programs, the Secretary may waive certain Medicaid requirements (statewide, comparability of services, and freedom of choice of provider.) There are four types of authorities under Section 1915(b) that states may request:

- (b)(1) mandates Medicaid Enrollment into managed care
- (b)(2) utilize a "central broker"
- (b)(3) uses cost savings to provide additional services
- (b)(4) limits number of providers for services

PROGRAM REQUIREMENTS:

A Section 1915(b) waiver program cannot negatively impact beneficiary access, quality of care of services, and must be cost effective (cannot cost more than what the Medicaid program would have cost without the waiver). Section 1915(b) waivers do not carry the evaluation requirements necessary for Section 1115 waivers, but an independent assessment is due for the first two waiver periods. More information is available about this requirement in the Independent Assessment Guidelines, published by the Centers for Medicare & Medicaid Services (CMS) in 1998 that may be downloaded below.

APPLICATION PROCESS

The application must be submitted to CMS by the Single State Medicaid Agency for review. Upon receiving the application, CMS has 90 days to approve, disapprove, or request additional information on the proposal. If CMS does not act within 90 days, the application is deemed approved. Section 1915(b) waiver programs are approved for 2-year periods, and states may submit renewal applications to continue these programs ongoing.

CMS developed templates for two types of waiver applications that may be downloaded below under "Downloads." Use of these templates is not required, but if used in conjunction with State Medicaid Manual instructions at section 2106-2112, could help CMS process the application in a timely manner.

- **PRIMARY CARE CASE MANAGER (PCCM) WAIVERS:** To view this document, you must first download the WordPerfect 5.1 version of the application. This file is in zipped format. After downloading the file to your site, you may extract it by using third party software. The resulting WordPerfect file (1915b1.wp) may then be viewed using your word processing software.

- **CAPITATED WAIVERS:** This waiver application was updated and improved in May of 1999.

HCBS Waivers Section 1915 (c)

States may offer a variety of services to consumers under an HCBS waiver program and the number of services that can be provided is not limited These programs may provide a combination of both traditional medical services (i.e. dental services, skilled nursing services) as well as non-medical services (i.e. respite, case management, environmental modifications). Family members and friends may be providers of waiver services if they meet the specified provider qualifications. However, in general spouses and parents of minor children cannot be paid providers of waiver services.

States have the discretion to choose the number of consumers to serve in a HCBS waiver program. Once approved by CMS, a state is held to the number of persons estimated in its application but has the flexibility to serve greater or fewer numbers of consumers by submitting an amendment to CMS for approval.

APPLICATION & APPROVAL PROCESS

The State Medicaid agency must submit to CMS for review and approval an application for an HCBS waiver, and the State Medicaid Agency has the ultimate responsibility for an HCBS waiver program, although it may delegate the day-to-day operation of the program to another entity. Initial HCBS waivers are approved for a three-year period, and waivers are renewed for five-year intervals.

PROVISIONS WAIVED

Section 1902(a)(1), regarding statewideness. This allows states to target waivers to particular areas of the state where the need is greatest, or perhaps where certain types of providers are available.

Section 1902(a)(10)(B), regarding comparability of services. This allows states to make waiver services available to people at risk of institutionalization, without being required to make waiver services available to the Medicaid population at large. States use this authority to target services to particular groups, such as elderly individuals, technology-dependent children, or persons with mental retardation or developmental disabilities. States may also target services on the basis of disease or condition, such as Acquired Immune Deficiency Syndrome.

Section 1902(a)(10)(C)(i)(III), regarding income and resource rules applicable in the community. This allows states to provide Medicaid to persons who would otherwise be eligible only in an institutional setting, often due to the income and resources of a spouse or parent. States may also use spousal impoverishment rules to determine financial eligibility for waiver services.

PROGRAM REQUIREMENTS

Within the parameters of broad Federal guidelines, States have the flexibility to develop HCBS waiver programs designed to meet the specific needs of targeted populations. Federal requirements for states choosing to implement an HCBS waiver program include:

- Demonstrating that providing waiver services to a target population is no more costly than the cost of services these individuals would receive in an institution.
- Ensuring that measures will be taken to protect the health and welfare of consumers.
- Providing adequate and reasonable provider standards to meet the needs of the target population.
- Ensuring that services are provided in accordance with a plan of care.

OLMSTEAD & HCBS WAIVERS

In the 1999 Olmstead v. L.C. decision, the Supreme Court affirmed the right of individuals with disabilities to receive public benefits and services in the most integrated setting appropriate to their needs. The Olmstead v. L.C. decision interpreted Title II of the American with Disabilities Act (ADA) and its implementing regulations. Medicaid can be an important resource to assist states in fulfilling their obligations under ADA. The HCBS waiver program in particular is a viable option for states to use to provide integrated community-based long-term care services and supports to qualified Medicaid eligible recipients.

CURRENT STATUS

Forty-eight States and the District of Columbia offer services through HCBS waivers, and Arizona operates a similar program under section 1115 research and demonstration authority. There is no federal requirement limiting the number of HCBS waiver programs a state may operate at any given time, and currently there are approximately 287 active HCBS waiver programs in operation throughout the country.

Combined 1915(b)/(c) Waivers

States may opt to simultaneously utilized section 1915(b) and 1915(c) program authorities to provide a continuum of services to disabled and/or elderly populations. In essence, states use the 1915(b) authority to limit freedom of choice, and 1915(c) authority to target eligibility for the program and provide home and community-based services. By doing this, states can provide long-term care services in a managed care environment or use a limited pool of providers.

In addition to providing traditional long-term care state plan services (such as home health, personal care, and institutional services,) states may propose to include non-traditional home and community-based "1915(c)-like" services (such as homemaker services, adult day health services, and respite care) in their managed care programs.

States can implement 1915(b) and 1915(c) concurrent waivers **as long as all Federal requirements for both programs are met.** Therefore, when submitting application for concurrent 1915(b)/(c) programs, states must submit a separate application for each waiver type and satisfy all of the applicable requirements. For example, states must demonstrate cost neutrality in the 1915(c) waiver and cost effectiveness in the 1915(b) waiver. States must also comply with the separate reporting requirements for each waiver. Because the waivers are approved for different time periods, renewal requests must be prepared separately and submitted at different points in time. Meeting these separate requirements can be a potential barrier for states that are considering going forward with such a program. However, the ability to develop an innovative managed care program that integrates home and community-based services with traditional state plan services is appealing enough to some states to outweigh the potential barriers.

Current State Initiatives

The Texas STAR+PLUS program, approved in January 1998, was the first concurrent 1915(b)/(c) program to be implemented. This mandatory program serves disabled and elderly beneficiaries in Harris County (Houston) and integrates acute and long-term care services through a managed care delivery system, consisting of three managed care organizations (MCOs) and a primary care case management system (PCCM.) The majority of STAR+PLUS enrollees are dually eligible for Medicaid and Medicare. Although STAR+PLUS does not restrict Medicare freedom of choice, an enhanced drug benefit is provided as an incentive to dual eligibles that elect to enroll in the same MCO for their Medicaid and Medicare services. Care coordination is an essential component of the STAR+PLUS model.

Michigan's Medicaid Prepaid Specialty Mental Health and Substance Abuse Services and Combination 1915(b)/(c) Medicaid Prepaid Specialty Services and Supports for Persons with Developmental Disabilities program were approved in June 1998. Unlike the STAR+PLUS program, which integrates acute and long-term care, Michigan's program "carves out" specialty mental health, substance abuse, and developmental disabilities services and supports and provides these services under a prepaid shared risk

arrangement. The purpose of this program is to provide beneficiaries an opportunity to experience "person-centered" assessment and planning approaches that provide a wider, more flexible, and mutually negotiated set of supports and services, thus enabling such individuals to exercise and experience greater choice and control.

Official Program Name	State	Waiver Authority
Kansas Managed Care Program 1915(b)	Kansas	1915(b)
Kansas Children & Family Services Behavioral and Rehabilitative Treatment Services Waiver	Kansas	1915(b)
Work Opportunities Reward Kansans (WORK)	Kansas	1115
Kansas MR/DD (0224.90.R2)	Kansas	1915 (c)
KS- Frail & Elderly Waiver (0303.90.R1)	Kansas	1915 (c)
KS - Physical Disabilities (0304.90.R1)	Kansas	1915 (c)
KS- Severe Emotional Disturbance (SED) HCBS Waiver (0320.90.R1)	Kansas	1915 (c)
KS - Head Injury (4164.90.R2.01)	Kansas	1915 (c)
KS- Technology Assisted Children (40165.90.R2A)	Kansas	1915 (c)

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Kansas Medicaid-HealthWave Program

What is Medicaid (Title XIX)?

Medicaid, also known as Title XIX, is a federal-state partnership program that provides health and long-term care services to people with low-incomes. These services include preventive, primary and acute health services for individuals, children and families. It also provides certain long-term care services, like nursing homes, for the elderly or people with disabilities.

Who is eligible for Medicaid in Kansas?

All persons applying for Medicaid are required to meet general, non-financial requirements, which include:

- Kansas Residency
- U.S. Citizen or Documented, Qualified Immigrant Status (except for coverage of emergency services under the SOBRA program)
- Verification of Citizenship and Identity (with a few exceptions)
- Use of other health insurance coverage before using Medicaid

What populations receive benefits through Medicaid?

- Children age 6 and older below 100% FPL ($16,600 a year for a family of 3)
- Children between ages 1 and 6 below 133% FPL ($22,078 a year for a family of 3)
- Families with minor children below the limit for Temporary Assistance for Families case assistance (approx. 37% FPL)
- Pregnant women and infants (ages 0-1) at or below 150% FPL
- Elderly and disabled SSI beneficiaries with income at or below 75% FPL ($7,500 a year for an individual)
- Employed persons with disabilities under 300% FPL
- Low-income seniors who receive Medicare, referred to as Qualified Medicare Beneficiaries (QMBs), Specified Low Income Medicare Beneficiaries (SLMBSs), and Qualifying Individuals (QIs)

What mandatory benefits are included in Medicaid?

Mandatory benefits that are provided through Medicaid include physician services; laboratory and x-ray services; inpatient hospital services; outpatient hospital services; early and periodic-screening, diagnostic, and treatment (EPSDT) services for individuals under 21; family planning and supplies; Federally-qualified health center (FQHC) services; rural health clinic services; nurse midwife services; and certified pediatric and family nurse practitioner

services. Mandatory long-term care benefits are institutional services and nursing facility (NF) services for individuals 21 or over.

What optional services are included in Kansas Medicaid?

The state offers the following optional services through the Medicaid program:

- Alcohol and Drug Abuse Treatment
- Attendent Care for Independent Living
- Audiological services
- Behavior Management
- Community Mental Health Center & Psychological Services
- Dental services (Limited to certain consumers)
- Durable medical equipment
- Medical Supplies, Orthotics, and Prosthetics
- Early Childhood Intervention
- Health Clinics
- Home or community-based services
- Hospice services
- Inpatient Pscyhiatric services
- Intermediate care facility services
- Local Education Agencies
- Local Health Department services
- Nursing services
- 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

How many Kansans are currently served by Kansas Medicaid?

The Kansas Medicaid program serves 250,336 individuals monthly, as of February 2007. This is a sharp decrease compared to this time last year, because federal citizenship and identity requirements have caused a Medicaid caseload reduction. On a monthly basis, the Medicaid program costs $170,454,530, which is approximately $681 per person enrolled in the program. However, this number varies depending on the service utilization and age, among other factors.

How is Medicaid financed in Kansas?

The federal government provides approximately 60 percent of the cost of Medicaid services. In other words, for every Medicaid dollar spent in Kansas, about 60 cents comes from the federal government; the State provides the remaining 40 cents. Medicaid is an open-ended entitlement for states.

When does a beneficiary's eligibility expire?

All beneficiaries must have eligibility redetermined at least once a year. Changes in income, resources and other circumstances during the year will impact the eligibility status for most adults. For children, Kansas applies a policy called continuous eligibility which allows children to be covered regardless of changes in income for up to one year.

How does Medicaid fit into the HealthWave program?

In 2001, the Medicaid managed care program was blended with the SCHIP program into the HealthWave program to help ensure a seamless product. HealthWave enables families with children who are eligible for SCHIP and Medicaid to have the same health plan and health provider for all family members. The HealthWave program also

serves Medicaid-eligible adults and children in the Temporary Assistance to Families (TAF) and Poverty Level Eligible (PLE) programs.

How much does a family pay in premiums for Medicaid?

The graph below outlines that a family must pay a premium of $20 or $30, depending on their income and the federal poverty level.

Percent of Federal Poverty Level (FPL)						
	176-200%		$30 Family	$30 Family	$30 Family	
	151-175%		$20 Family	$20 Family	$20 Family	
	134-150%			No Premium	No Premium	
	101-133%				No Premium	
	38-100%					
	0-37%					
Age in Years		Pregnant Women	Under 1	1 to 5	6 to 19	Adults

How can a person apply for Medicaid?

An application form can be found at schools, places of worship, medical providers, www.kansashealthwave.org, or may be mailed to you by calling 1-800-792-4884. The form is then mailed in along with supporting documentation such as wage information and citizenship and identity documentation to the Kansas Family Medical Clearinghouse, which is responsible for processing and eligibility determination for both Medicaid and SCHIP.

What are citizenship and identity documentation?

If a person applies for Medicaid, they must provide proof of U.S. citizenship and identity, as outlined in the Deficit Reduction Act of 2005. A U.S. Passport, Certificate of Naturalization or Certificate of Citizenship will verify both citizenship and identity. If a person does not have any of those documents, they must provide two forms of documentation, one for citizenship and one for identity. Citizenship documents include birth certificate or birth record, adoption records showing place of birth or military record. Identity documents include driver's license, federal, state or local id, military id, Native American Tribal document. A school id, school records, medical records or licensed or registered daycare documents will verify the identity of a child under 16 years of age. If you need help with your application, call 800.792.4884.

How can a person contact HealthWave, the Medicaid program?

Mail:
P.O. Box 3599, Topeka, KS, 66601

Phone:
Toll Free: 1-800-792-4884
Topeka Area residents 368-1515
TTY: 1-800-792-4292

Fax:
Toll Free: 1-800-498-1255
Topeka Area residents 431-7194

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March 19, 2007

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Health for All Kansans Steering Committee approves health reform legislative package

KHPA Board to review and approve package tomorrow

Calling it the first step to health reform in Kansas, the Health for All Kansans Steering Committee approved a health reform legislative package today, hopeful the Legislature approves it and the Governor signs it.

"Over the past several months of steering committee meetings, I have been impressed by the energy and focus from these members to accomplish great reform designed to improve the health of all Kansans. Today, we made a critical down payment to Kansans," said Marci Nielsen, PhD, MPH, Executive Director of the Kansas Health Policy Authority (KHPA). "I am encouraged by the progress we have made and will continue to make as we move forward together, working across aisles for the benefit of the people we serve."

Tomorrow, at the monthly Board meeting, the Kansas Health Policy Authority Board will review and approve the package, before sending it to the Kansas Legislature.

The legislative package approved today for passage this session includes:

- **Early detection and screening for newborns.** Expand screening for newborns from our current level of four tests to twenty-nine which will lead to early diagnosis and intervention that will pay immeasurable benefits in future years.
- **Medicaid outreach and enrollment expansion.** Expand the marketing of programs available to the public in order to educate Kansans about the Healthwave program and health and wellness through: (1) designing an online application and screening tool for potential beneficiaries, (2) developing and implementing a targeting marketing campaign and (3) employing additional outreach workers.
- **Consider DRA Flexibilities.** The Deficit Reduction Act (DRA) allows moving waiver services into the Medicaid state plan, designing benchmark benefit packages with more cost sharing, and exploring innovative reform models through Medicaid Transformation Grants.
- **Cover Kansas pregnant women, children and/or low-families through Premium Assistance.** Premium assistance programs use federal and state Medicaid and/or SCHIP funds to subsidize the purchase of private health insurance. There are various models that can be used.
- **Promoting price and quality transparency.** Promote Transparency for Kansas Consumers and Purchasers through a two-phased approach that collects data currently available in one convenient location (through KHPA and State libraries), and then adds health care pricing and quality data (as determined by the KHPA Data Consortium – comprised of providers, consumers, and purchasers).

This kind of information ... also help to reduce utilization of care that is not evidence-based or is of questionable quality, which can serve to reduce overall health care costs.

- **Increasing Health Information Technology/Exchange (HIT/HIE).** Building on the work of the Health Care Cost Containment Commission and the KHPA staff, the state should establish an Implementation Center for HIE in Kansas through a public/private entity as a single coordination point for Kansas HIE efforts.

Once approved by the KHPA Board tomorrow, the package will be introduced in the Legislature yet this session.

Between April and November of 2007, KHPA will develop a more long-term health reform plan for consideration during the 2008 Legislative session.

The Health for All Kansans Steering Committee was created by the Kansas Health Policy Authority Board to advise the Board, Governor and legislative leadership, including the Joint Committee on Health Policy Oversight, on initiatives and ways to reform health in Kansas, making health services more accessible, through legislation this session.

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State Children's Health Insurance Program (SCHIP)

What is the State Children's Health Insurance Program (SCHIP-Title XXI)?

SCHIP, also known as Title XXI, was implemented in Kansas in 1999. SCHIP provides health care coverage for low-income children in families with incomes up to 200% of the federal poverty level who are not Medicaid-eligible. It is a federal-state partnership program.

Who is eligible for SCHIP in Kansas?

Kansas provides free or low-cost health insurance coverage to children in this program who:

- Are under the age of nineteen;
- Do not qualify for Medicaid;
- Have family incomes under the 200% of the FPL; and
- Are not covered by state employee health insurance or other private health insurance.

Eligibility is continuous for twelve months and re-established annually. The family must meet all eligibility criteria and have paid any applicable premiums from the prior year to be re-enrolled for a new twelve-month period.

How is SCHIP financed?

Nearly all health care services purchased by Medicaid and HealthWave are financed through a combination of state funds and federal matching funds. Under SCHIP, the federal government provides approximately 72 percent of the cost up to a maximum allotment, and the State provides the remaining 28 percent and any excess spent above the federal allotment.

How does SCHIP fit into the HealthWave program?

In 2001, SCHIP was blended with the state's Medicaid program into the HealthWave program to help ensure a seamless product. HealthWave enables families with children who are eligible for SCHIP and Medicaid to have the same health plan and health provider for all family members. The HealthWave program not only serves SCHIP-eligible children, but also Medicaid-eligible adults and children in the Temporary Assistance to Families (TAF) and Poverty Level Eligible (PLE) programs.

How many children are enrolled in SCHIP?

As of March 2007, 34,414 children were enrolled in SCHIP. The average cost per child per month is $140.56. However, this varies depending on the number of children enrolled each month, as well as variations in the

children's ages, service utilization and county of residence. In FY 2006, 56,000 Kansans received services through the SCHIP program at a cost of $62.4 million.

How can a person apply for SCHIP?

An application form can be found at schools, places of worship, medical providers, www.kansashealthwave.org, or may be mailed to you by calling 1-800-792-4884. The form is then mailed in along with supporting documentation such as wage information to the Kansas Family Medical Clearinghouse, which is responsible for processing and eligibility determination for both Medicaid and SCHIP.

How can a person contact HealthWave, the SCHIP program?

Mail:
P.O. Box 3599, Topeka, KS, 66601

Phone:
Toll Free: 1-800-792-4884
Topeka Area residents 368-1515
TTY: 1-800-792-4292

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2007 Short Term Legislative Package for Access for All Kansans

Early detection and screening for newborns. Expands screening for newborns from our current level of four tests to twenty-nine. This effort represents a true and meaningful step in the direction of early diagnosis and early intervention that will pay immeasurable benefits in future years.
FY 2008 SGF: $191,000; All Funds: $1,189,942

Recent Action: Funded in the Governor's budget. Passed the House on March 16, 2007, added $1,200,000 to pay for newborn screens for both private and public health insurance programs.

Medicaid outreach and enrollment expansion. Expands the marketing of programs available to the public in order to educate Kansans about the HealthWave program and about health and wellness by: (1) designing an online application and screening tool for potential beneficiaries, (2) developing and implementing a targeting marketing campaign and (3) employing additional outreach workers.
FY 2008 SGF: $336,247 (FY 2008) All Funds: $ 822,112 (FY 2008)

Consider Deficit Reduction Act (DRA) Flexibilities. Supports the opportunities provided through the DRA to allow moving waiver services into the Medicaid state plan, designing benchmark benefit packages with more cost sharing, and exploring innovative reform models through Medicaid Transformation Grants.

Recent Action: The Kansas Medicaid program has received a Medicaid Transformation grant for $910,000 which will combine predictive modeling with training by KU clinicians to assist case managers in coordinating preventative care for disabled Medicaid beneficiaries with the goal of improved health outcomes. We have also submitted a Long Term Care Partnership grant together with the Kansas Department of Insurance. Premium assistance described below is included in the package. Other DRA flexibilities will be explored in broader health reform as outlined the enabling legislation.

Promoting price and quality transparency. Promotes transparency for Kansas consumers and purchasers through a two phased approach that collects data currently available in one convenient location (through KHPA and State libraries), and then adds health care pricing and quality data (as determined by the KHPA Data Consortium – comprised of providers, consumers, and purchasers). This kind of information will also help to reduce utilization of care that is not evidence-based or is of questionable quality, which can serve to reduce overall health care costs.
SGF: $425,682 (FY 2008) All Funds: $543,790 (FY 2008)

Increasing Health Information Technology/Health Information Exchange (HIT/HIE). Building on the work of the Health Care Cost Containment Commission (H4C) and the KHPA, the state will develop and establish an "Implementation Center for HIE" in Kansas through a public/private entity in order to have a single

coordination point for Kansas HIE efforts.
SGF: $750,000 (FY 2008) All Funds: $1 M (FY 2008)

Cover Kansas Pregnant Women, Children and/or Low Income Families through Premium Assistance. Creates a phased-in premium assistance program in order to help low income uninsured families in Kansas to purchase private health insurance, either through their employer or through state procured health insurance plans. Research suggests that better health outcomes are associated with all family members receiving access to care or health insurance through the same plan, and thus, have a "medical home". Although children in Kansas are eligible for Medicaid and/or the State Children's Health Insurance Program up to 200 percent of the federal poverty level (FPL), Kansas currently has one of the lowest rates of Medicaid eligibility in the nation for poor parents (less than 38 percent of the FPL). Premium assistance in Kansas will be phased in over four years, with a "legislative trigger" after the first two years to evaluate the program and ensure that funding is available.

Premium Assistance options this session:

- Competitively bid state-procured health plans: For low income uninsured families, Medicaid (state and federal share) would pay for premiums for state-procured private health insurance to be offered to low income children and their parents. Because children eligible for Medicaid are required by federal law to receive certain services, the private insurance plans would be supplemented by "wrapping around" private health insurance coverage with fee-for-service Medicaid.
- Employer-sponsored insurance (ESI) buy-in: For low income uninsured parents who have access to employer sponsored private health insurance, Medicaid would pay the employee share of the health insurance premium for families and then "wrap around" children's coverage with fee for service Medicaid.

Reduces the number of uninsured Kansans

- Phases-in health insurance coverage to families with Medicaid-eligible children, beginning with those families who are already eligible for Medicaid (i.e. those at approximately 37% of the federal poverty level)
- Creates a "medical home" for families because premium assistance brings parents and children into the same private health plan
- Protects health care benefits currently offered to children

Expands private health insurance coverage

- Expands coverage solely through private health plans, promoting competition in the health insurance marketplace
- Increases health plan choices available to low-income families, similar to the State Employee Health Benefits Plans (includes HSA)
- Puts Medicaid benefits for parents on a par with privately-insured families
- Prepares the way for further reforms to improve markets and expand health insurance coverage
- Can be used to incentivize health promotion and disease prevention within private plans
- Can be "phased in" over three or four years to dovetail with additional health insurance market reforms, such as a health insurance connector.

Leverages federal dollars toward broader health reform

- Draws in federal matching funds and takes advantage of Deficit Reduction Act Flexibilities – giving Kansas an opportunity to "catch up" with other states in terms of federal support for increasing access to health care
- Together with increased transparency of health care cost and quality as well as information technology, can create partnerships with the US Department of Health and Human Services

Cost and Coverage Options Under a Premium Assistance Plan – these are preliminary estimates only

Phase-In	**Year 1**	**Year 2**	**Year 3**	**Year 4**	***FULL PHASE IN***
Percent of Federal Poverty Level (FPL)	**Ramp up (Those under 37% FPL)**	**Under 50% FPL**	**50-74% FPL**	**75-99% FPL**	***Total under 100% FPL***
Number of parents covered	N/A	8,500	7,000	8,500	*24,000*
Estimated administrative costs	$.5M	$1.5M	$2M	$2.25M	$2.25M
SGF: Premium costs		$11M	$9M	$11M	*$31M*
Federal Matching Funds		$16M	$14M	$16M	*$46M*
Total Costs		$27M	$23M	$27M	*$77M*

10-23

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March 20, 2007

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KHPA Board sends to Legislature health reform plan to decrease number of uninsured Kansans

As the leading agency on health and health care, the Kansas Health Policy Authority Board has approved a legislative package that increases accessibility of health care to Kansans and seeks to reduce the number of uninsured Kansans. This package, approved yesterday by the Health for All Kansans Steering Committee, is a short-term health reform plan, with a larger and more expansive long-term reform plan coming in the fall of 2007 by the Kansas Health Policy Authority (KHPA).

"We already have health coverage for all Kansans, through our emergency rooms, but it is the most expensive and shifts the cost burden from the uninsured to the insured. Our goal is to bring reform that provides coverage to all Kansans through a more efficient and affordable means," said Connie Hubbell, Chairperson of the Kansas Health Policy Authority Board.

"The package that we will be sending to the Legislature this session is a down payment plan for a more broad long-term reform package to be announced in November," stated Marci Nielsen, PhD, MPH, Executive Director of the Kansas Health Policy Authority. "The Health Policy Authority has embraced the charge given to us by the Legislature and the Governor to provide affordable access to health for all Kansans. There is more work to be done, and we will be working in partnership with stakeholders to develop Kansas-specific reform options."

This legislative package approved for introduction this session is estimated to decrease the number of uninsured by ten percent. Currently, there are 300,000 Kansans who are uninsured. The package includes:

- Early detection and screening for newborns
- Medicaid outreach and enrollment expansion
- Consideration of Deficit Reduction Act (DRA) flexibilities
- Cover Kansas pregnant women, children and/or low-income families through premium assistance
- Promote price and quality transparency
- Increase health information technology/exchange (HIT/HIE)

"There's a health care crisis in our state, and it's going to take effort from all of us to make quality health care affordable again," said Governor Kathleen Sebelius. "I want to thank the members of the steering committee for their hard work in putting this package together. It's a good first step toward meeting my goal of affordable health coverage for all Kansans. I urge the Legislature to take these important steps, this year and will continue working with the steering committee to develop multi-year coverage for all Kansans," said Sebelius.

10-24

Yesterday, the enabling legislation, charging the KHPA to direct development of "Health for All Kansans" legislation for adoption in 2008 and implementation in 2009 and 2010, was passed out of Senate Health Care Strategies Committee. The legislation also calls for the KHPA to provide analysis of the Kansas Health Care Insurance Connector, a model for a voluntary health insurance connector, and other health reform and transformation options. It is Substitute for SB 309.

"The Kansas Health Care Insurance Connector offers the best opportunity to bring forward transformational change in health care so that more Kansans can be insured in a fiscally sustainable manner," said Senator Jim Barnett, member of the Health for All Kansans Steering Committee. "The groundwork has been laid to make true progress for both short-term and long-term health care reform."

Between April 1 and November of 2007, KHPA will develop health reform options as outlined in the enabling legislation, in collaboration with the four Advisory Councils. Analysis for these reform options will be provided by national experts with experience in state health reform. By November 1, 2007, KHPA will deliver the health reform options to the Board, Governor, and legislative leadership for their consideration.

The short-term health reform package will be introduced in the Senate Ways and Means and House Appropriations Committees for consideration this session.

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