Approved: February 12, 2008
Date

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

The meeting was called to order by Chairman Brenda Landwehr at 1:30 P.M. on February 6, 2008 in Room 526-S of the Capitol.

All members were present except:
Representative Kiegerl, excused
Representative Colyer, excused
Representative Quigley, excused
Representative Hill, excused

Committee staff present:
Dianne Rosell, Revisor of Statutes Office
Melissa Calderwood, Kansas Legislative Research Department
Cindy Lash, Kansas Legislative Research Department
Chris Haug, Committee Assistant
Shelley Barnhill, Committee Assistant

Conferees appearing before the committee:
Fred Schuster, US Department of Health and Human Services
Admiral John Babb, Regional Health Administrator, US Dept. Of Health and Human Services
Patrick Cogley, Regional Inspector General, US Dept. Of Health and Human Services
Mandy Hanks, Centers for Medicare and Medicaid Services for State of Kansas, US Dept. Of Health and Human Services
Robert Epps, Centers for Medicare and Medicaid Services (Provider Liaison), US Dept. Of Health and Human Services

Others Attending:
See Attached List.

Bill Introductions - Representative Flaharty, Introduced a bill on Family leave and making it easier to take leave, fashioned after state of Washington. Representative Morrison Seconded. Motion Carried.

Fred Schuster, Regional Director US Department of Health and Human Services, thanked the chair for the opportunity to come and present every year. They had originally had someone from the Food and Drug Administration and Aging and someone from ACF that handles children's issues to come but they were unable to come because of the weather. He then turned it over to Admiral John Babb for the first presentation.

Admiral John Babb, Regional Health Administrator, Health and Human Services. His presentation is attached as (Attachment 1). Representative Flaharty stated that better health will improve quality of life for an individual. Recently she read a remark last weekend that while that was great for the individual it wouldn't save the state more money because the longer life will cost the state more money. Admiral Babb saw the article and he knew that was going to come up. He said, "It's downright inconsiderate for us healthy folks to continue to live". Vice Chairperson Mast asked about two things. "I saw an article recently about radon killing more people than 2nd hand smoke. Can you verify that?" Admiral Babb said he couldn't verify that, but could find out. Second question was about how much money will it cost the state to pay for people on Medicaid. Admiral Babb said Medicaid pays for the health related costs associated with smoking, but it doesn't pay for cigarettes. Chairperson Landwehr asked for a copy of what he presented so the secretary would have it for the minutes. He will provide this.

Patrick Cogley, Regional Inspector General for the US Department of Health and Human Services. Mr. Cogley gave an overview of what his office does and focus's on. His presentation is attached as (Attachment 2). Chairperson Landwehr asked if he could give an example of a contingency fee contract. Mr. Cogley said one in particular in Kansas that is no longer in place but the contingency contractor about 5 years ago was in the area of child welfare services under Medicaid and there was a state only program at the time and the contingency fee contractor saw their were federal dollars available if you rolled it into Medicaid they would be eligible for Medicaid. They were trying to complete a retro-active claim and tried to go back several years

and put together a claim. There are agenda's are basically to find untapped federal dollars. We are looking at the provider area and are trying to make sure providers are billing for eligible services and in the correct amounts. Representative Otto had a concern about the emergency care for illegal aliens from a hospital perspective, to me someone comes in with pneumonia, do they give them a couple of pills and push them out the door. To me, if someone comes in for emergency care, they should get them well enough to get them out the door. Mr. Cogley said every hospital has to treat an emergency. The hospital is in a catch 22. Basically the issues we are looking at are there are some states put them in a medicaid program, give them a medicaid, card for a temporary basis and then they go out and get doctors services 2 or 3 months later. Chairperson Landwehr mentioned that he said every hospital has to treat an emergency. We have a unique situation in KS where we have speciality hospitals. Mr. Cogley said they would have to have an acute care facility. Chair person Landwehr asked what does ACF stand for? Mr. Cogley said, Agency for Children and Families. Chairperson Landwehr asked if he could elaborate on the DSH payment issue. Mr. Cogley said DSH is Disproportionate Share for Hospitals. It's money to compensate for uninsured. There is both Medicaid and Medicare DSH money. Most common they are intercity hospitals in intercity where you have poorer, uninsured people. In the early 1990s legislation said that states can't give DSH money to hospitals with utilization rate under 1%. There were some state mental hospitals involved. There is a big population that is the state's responsibility and the federal government won't cover them under Medicaid. It is a certain age group that falls under the state's responsibility.

Mandy Hanks, Centers for Medicare and Medicaid Services for State of Kansas. Ms. Hanks gave an overview of the Medicaid program with the US department of Health and Human Services. Her presentation is attached as (Attachment 3). Rep. Ward asked how much DSH dollars KS has but hasn't spent. Ms. Hanks said for 2007 it is 2.9 M. Rep. Ward asked about the graduate medical education regulation being postponed, how long has it been postponed? Ms. Hanks said it has been postponed until May 25, 2008. Rep. Ward asked when it was postponed. Ms. Hanks did not know, but said she would find out. Representative Storm said that Representative Ward asked about the 2.9 M. I believe you said you received it in the past tense. Which is it? Ms. Ward said the state receives a 2.9 M allotment that we have. Representative Ward said, "I'm confused, I don't understand how we get this money"? Ms. Hanks stated you can only use 2007 DSH dollars for services in 2007. Representative Ward asked if there is a state match required to get this money. Ms. Hanks stated the way she understood it is an allotment to the state. She said she would do more research and get back to us. Representative Ward wanted to know how we go about accessing the money. Andy Allison, Deputy Director of Kansas Health Policy Authority said the Federal DSH allotments are a ceiling on the federal matching dollars that are available. So it's not like an unmatched federal grant that we haven't received. Representative Ward asked why wouldn't we be able to use it? Mr. Allison said there were not enough hospitals that qualified for the match. Representative Ward wondered if it was a state designation or federal designation, who does the qualification that shorts us the 2.9 million? Mr. Allison said it was a state designation subject to federal rules. The formula is up to us. We endeavor to work with hospitals to initiate a new methodology that will always use all of the available dollars. That proposal is now at CMS for review. We submitted that in September. Representative Ward asked for clarification, the plan has been redone so we don't loose out on the 2.9 mil again. Can we go back and get that 2.9 mil because there are a lot of hospitals that would benefit from that. Mr. Allison did not think we could do that. Chairperson Landwehr said if there is money available that we could to back on, it is worth it to pursue. Our fiscal year and the federal fiscal year are different. Ours is July 1 and theirs is October. Mr. Allison said he could get a response back to the committee if there are any dollars we can get back. Representative Crum asked what our disproportionate share was in 2007. Mr. Allison said there is a portion we devote to state mental institutions and I think that is 16M. The portion going to community hospitals is about 44 million per year, all funds.

Robert Epps, Centers for Medicare and Medicaid Services (Provider Liaison) - Mr. Epps gave a presentation on Medicare Updates. This presentation is attached as (Attachment 4). Mr. Epps said he was aware of a large public hospital in New York City that added a large area next to their emergency room for cost savings or cost control. The way it worked in Kings County Hospital in NYC, involved patients being pulled out of acute setting and placed in an outpatient setting. This hospital received 90% of their money from Medicaid. Chairperson Landwehr said, " the hospital I am most familiar with, you come into door, they ask what your issue is, they take your vitals then they do your paper work for admissions. At what point do they make a triage decision that it really is an emergency. A lot of times what happens is you've got working parents that cannot get out from 8-5 and the doctors in the ER all that are available." Mr. Epps didn't know the answer

to that. Chad Austin said what he thought the chairperson was referencing were the Impala rules. If someone comes into the hospital, we have to assess them. Chairperson Landwehr said, "Once you are into that the billing starts. If we could get these folks to a clinic we could save some money. Do we need to request a waiver of, or a pilot program and see how it works?" In Wichita we actually had a hospital that put a clinic right next to an ER, but once they hit that ER door, they can't shift them down. Right now they are doing 6 days a week from 5 to midnight. A lot of kids end up in the ER because of working parents. Representative Trimmer asked about the statement about not covering or reimbursing any institutionally acquired infections. Mr. Epps said there was a menu going forward from October. There is a relatively small menu of specific hospital required conditions. The plan would be if this works it would be expanded. There are a limited number of conditions. Representative Crum asked, "could you give us an overview of the physical liability of Medicare regarding prescription drug plans in place. Are the premiums charged to medicare recipients in any way cover the cost to CMS?" Mr. Epps said, "in no way shape or form." Medicare in it's current fiscal state is not sustainable. Legislation passed in 2003, one feature said when 45% of total medicare expenditures come from general fund sources, a trigger mechanism goes into affect and obliges the President to come forth with a plan to get it back under the 45% threshold. The last two trustees reports have indicated we have tripped over that threshold. Representative Crum asked if the president acted. Mr. Epps said he wasn't sure. Representative Crum asked if congress is obliged to take any steps to put the medicare program on a more sound footing. Representative Otto said he heard a TV program that our national dept is 10 trillion but when you throw in our commitment it is 58 trillion. Mr. Epps said he has heard that figure. He said Medicare and Social Ssecurity have a lot of similarities, they are both driven by the demographics of the baby boomers. Chairperson Landwehr asked about the open enrollment that medicare and advantage plans offer in the Fall, that companies are required to explain every plan. Why do you have to do every single plan? It also has to be a face to face explanation. Mr. Epps said he was not aware of this. He said he would find out about this.

Chairperson Landwehr asked Ms. Hanks about the GMD program. Could she elaborate on the changes? Ms. Hanks said that Medicaid will not be a source of funding for graduate medical education so with physician training programs, medicaid will not be funding.

Chairperson Landwehr adjourned the meeting at 2:50 p.m.

HOUSE HEALTH AND HUMAN SERVICES COMMITTEE GUEST LIST

DATE: February 6, 2008

NAME	REPRESENTING
John Babb	Regional Health Administrator, HHS
Robert Epps	Centers for Medicare & Medicaid - Provider Liaison
Patrick Cogley	Regional Inspector General, HHS
Sean Miller	Capitol Strategies
Fred Schuster	Regional Director, HHS
Mandy Hanks	Centers for Medicare & Medicaid Services - KS State Rep.

Presentation by Admiral John Babb, US Dept. of Health Human Services

* For the first time in our history, it is very likely that today's children will have a shorter lifespan than their parents. Approximately 60% of overweight children aged 5 to 10 have at least one PHYSIOLOGICAL risk factor for heart disease, stroke, and diabetes – such as high cholesterol, triglycerides, blood sugar, or blood pressure. Twenty years ago, these were problems almost exclusively found in ADULTS.

* Former Surgeon General Richard Carmona, recently said that the biggest risk to America's security is NOT terrorism, but obesity.

* A recent study projects that of all American children born in the year 2000 – 33% of males and 39% of females – will become diabetic in their lifetime.

* Here in Kansas, in 2007 KU performed a statewide needs assessment of Kansas physicians. They found that Kansas doctors identified DIABETES as THE disease of greatest concern.

* The science says children need 60 minutes of physical activity per day. They all need LESS THAN 2 hours of TV and video time per day. And they all need at least 5 helpings of fruit and vegetables per day.

* Some are quick to point out that No Child Left Behind requires more time in the classroom – not on the playground. But 16 separate studies recently reviewed by the Robert Woods Johnson Foundation show that test scores go UP when children have time for physical activity, and discipline problems go DOWN when there is adequate physical activity.

* We know from the 2006 Surgeon General's Report on the Health Consequences of the Involuntary Exposure to Tobacco Smoke that secondhand smoke kills over 50,000 nonsmoking Americans annually.

* Examples of Kansans that are least able to protect themselves:

A) If Mothers are exposed to smoke during pregnancy, the risk of having low birth-weight babies is far higher. This can result in a number of health problems – including 1) poorly developed lungs and kidneys, 2) higher infant mortality, 3) Attention Deficit Hyperactivity Disorder, 4) aggressive behaviors, 5) poor school performance, and 6) Infants exposed to secondhand smoke,, or exposed during pregnancy, are 4 to 7 times as likely

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Attachment 1

to die from SIDS 7) These children also have thicker walls in the carotid arteries in their necks, which can lead to a permanently higher incidence of stroke and heart attack.

B) The danger of secondhand hand smoke exposure does not end in infancy. Being exposed to secondhand tobacco smoke raises adolescents' risk of metabolic syndrome – a disorder associated with excessive belly fat, elevated blood pressure, higher blood glucose, and increased blood cholesterol – all problems which increase the adolescent's chances of heart disease, stroke, and type II diabetes

C) The level of tobacco smoke in bars and restaurants can be far higher than that measured in the homes of smokers, simply because so many people are smoking. A non-smoking employee might inhale the equivalent of 16 cigarettes in an 8 hour shift.

D) In March 2002 the city of Bowling Green, Ohio implemented a ban on smoking in workplaces and public places. Hospital admissions for heart attacks were measured one year and three years after the ban was enacted. There was a 39% decrease after one year, and a 47% reduction after 3 years, in hospitalizations for heart attack.

Similar study results were found in Helena, MT, Pueblo, CO, Bloomington, IN, the state of New York, and the entire nations of Ireland and Scotland.

The sad fact is that people who have **pre-existing heart disease** can actually suffer a heart attack after merely being in a business where second hand smoke is present for AS LITTLE AS 30 minutes. The experience of governments passing a clean air ordinance for all workplaces, has been that they can expect a dramatic reduction in heart attacks.

* The CDC recently stated that **the ultimate cost to society of a pack of cigarettes was $10.28** – that includes health care costs, absenteeism, lost productivity, and shortened lifespan. Kansas collects 79 cents toward that cost through your state tobacco tax. There is a very direct cost to the state treasury of $1.28 per pack, just for the state's portion of Medicaid costs that are due to tobacco-related diseases. And that does not address the loss of revenue to Kansas hospitals and clinics that provide un-compensated care for those same diseases.

* An added benefit of the proposed tobacco tax increase is that CDC studies show that for every 10% increase in the cost of cigarettes, there is a corresponding decrease in smoking by 4% of adults, and 6% of adolescents.

* With the increased tax revenue, it's projected by KDHE that breast and cervical cancer screening for Kansas women could be expanded from a current 6 month offering to a year round program. Screening for colorectal and prostate cancer could also be added.

* 24 states now have smoke-free workplace legislation in place. 40 of the 50 largest American cities are likewise protected. The entire nations of England, France, Iceland, Ireland, Northern Ireland, Italy, Lithuania, New Zealand, Norway, Scotland, Sweden, Turkey, Uruguay, and Wales now protect every worker and every customer in their countries from second hand smoke. Much has happened in the 19 months since the Surgeon General's Report was published in 2006.

Patrick Cogley

Office of Inspector General—Office of Audit Services

Program Audits

OAS conducts financial and performance audits of departmental programs and operations to determine whether objectives are being achieved, which aspects of programs need to be performed more efficiently, and to identify systemic weaknesses that give rise to fraud, waste, or abuse. OAS also provides leadership and direction in carrying out the mandates of the Chief Financial Officers Act of 1990 and the Government Management Reform Act of 1994 relating to financial statement audits.

Our audit workplan is published each year on our website

http://oig.hhs.gov/reading/workplan.html

Medicaid

1) State vs. Federal Share (enhanced payment rate)

Medicaid Disproportianate Hospitals—payments to eligible hospitals (IMDs)
Targeted Case Management
Drug Rebates
Family planning services
Contingency Fee contracts

2) Medicaid providers
--hospital outlier payments
--emergency services for undocumented aliens

3) Financial Audit perspective/OMB
Medicaid and State Children's Health Insurance Program Payment Error Rate Measurement
Medicaid Eligiblity in Multiple States

ACF

Foster Care and Adoption Assistance Training Costs (enhanced rate)
TANF error rate (stat sample) Minnesota

Select State for Audit
Dollars/Size of Program
Issues
Contingency Fee

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Attachment 2

Good Afternoon, Madame Chairperson, and the entire committee. My name is Mandy Hanks, and I am the Kansas State Representative in the Division of Medicaid and Children's Health Operations, with the Centers for Medicare & Medicaid Services, which I will refer to as CMS throughout this presentation. I want to thank you for the opportunity to update the Health and Human Services committee on items of interest regarding Medicaid and the State Children's Health Insurance Program.

Last year, we provided you with an overview of the Deficit Reduction Act of 2005, which is referred to as the DRA. Today I would like to take this time to update you on the progress Kansas has made in implementing some of those provisions, secondly highlight some initiatives from the President's Budget, and lastly update you on a number of regulations CMS has proposed.

To update you on KS progress with some of the DRA provisions, Kansas was 1 out 10 States to be awarded a demonstration grant for home and community based alternatives for children at risk or already residing in a psychiatric residential treatment facility through provision 6063. CMS approved Kansas' Psychiatric Residential Treatment Facility Home and Community Based Alternative waiver on January 3, 2008 with an upcoming effective date of April 1. The waiver will remain in effect through September 30, 2012. Kansas will then have the option to continue this Home and Community-Based Services or HCBS waiver with the special psychiatric residential treatment facility level of care criteria. Keep in mind that only the 10 States awarded this grant will have this opportunity available to them.

Kansas was also awarded a 2nd round grant award for the Money Follows the Person Rebalancing Demonstration through provision 6071. This provision allows Kansas to receive enhanced federal dollars for home and community based services for individuals who choose to transition from institutional settings to the home and community based setting of their choice. Kansas is currently in the preliminary stages of developing their operational protocol for this program.

I would also like to congratulate Kansas on fully implemented provision 6035, which required all Medicaid applicants and recipients to provide documentation of their citizenship and identity beginning July 1, 2006. With full implementation of this requirement, Kansas' workload has increased dramatically and did result in a backlog of applications and redeterminations from 2006. CMS commends Kansas on its efforts in the elimination of the backlog and continues to have discussions with the State to help find ways to help deal with the challenges of this new requirement.

Kansas is also working with CMS on a pending State plan Amendment, 08-01, to expand private insurance for low-income families by using section 6044 of the Deficit Reduction Act to design a premium assistance program called "Kansas Healthy Choices." The State currently plans to offer a benchmark equivalent benefit package to these individuals based of the Kansas' State Employee Health Plan.

Along with various provisions of the DRA to aid in Medicaid Reform that I discussed above, I would also like to highlight four areas from the President's 2008 budget.

The first area is the Affordable Choices Initiative, which allows States the flexibility through an 1115 waiver to waive statutory requirements permitting States to use unspent Disproportionate Share Hospital dollars, also known as DSH dollars, to assist individuals with poor health and limited income to purchase health insurance. Kansas currently has 2.9 million unspent DSH dollars for Federal Fiscal Year 2007.

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The second area is the State Children's Health Insurance Program, also referred to as SCHIP, and its Reauthorization. I am happy to report that this program was reauthorized on December 29, 2007 through the Medicare, Medicaid, and SCHIP Extension Act of 2007. It extended federal funding through March 31, 2009.

The two final areas of the President's Budget that I would like to touch upon include Pharmacy Reform and Program Integrity of the Medicaid program to combat waste, fraud, and abuse. At this time, the Medicaid requirement for the use of tamper proof prescription pads on all non-electronic prescriptions to prevent fraud has been delayed until April 1st to allow States more time to come into compliance. Also based on a lawsuit against the rule establishing a new formula for setting the federal upper limits for reimbursing pharmacy drugs, as established through the DRA provision 6001, the U.S District Court for the District of Columbia has imposed a preliminary injunction until the case can be reviewed.

Lastly, I would like provide an update on some of CMS regulations. CMS has also just recently issued the Targeted Case Management rule, effective March 3, 2008, based on the DRA provision, section 6052. This regulation clarifies the Medicaid definition of covered case management and targeted case management services. It specifies excluded activities to address concerns around improper billing of non-Medicaid services to the Medicaid program. It also ensures significant beneficiary protections through comprehensive and coordinated services to meet the needs of beneficiaries. CMS approved Kansas State plan amendment 07-06 on December 6, 2007, which addresses many of these new requirements.

In addition to the targeted case management regulation, a 6-month moratorium has been put in place until June 30, 2008 on the Rehabilitation and School-based Services regulations. The rehabilitation regulation clarifies the definition of rehabilitative services covered under Medicaid. The School-based Services regulation eliminates reimbursement for SBS administrative expenditures and costs related to Transportation of school-age children between home and school.

Legislation was also passed delaying implementation on the Public Provider Cost Limit and Graduate Medical Education rules until May 25, 2008. The public provider cost limit regulation changes the unit of government definition as well as establishes a cost limit on government operated providers. The Graduate Medical Education regulation clarifies that Medicaid funds will no longer be available as a source of funding for Graduate Medical Education such as physician training programs.

With all these changes in regulations and new initiatives that I have discussed above, CMS and the Kansas Health Policy Authority continue to work in collaboration to address issues, new requirements, and discuss various opportunities within the Medicaid program.

Concluded Comments. Questions.

Kansas Talking Points: Medicare Updates

02/06/2008

Medicare Prescription Drug Program

- **Outpatient prescription drug coverage was added to the Medicare program in January 2006.**

- **As you know there were a few bumps in the road during the initial implementation phase.**

- **Thankfully, most of those bumps have been smoothed out and today over 90% of Medicare beneficiaries have access to prescription drug coverage.**

- **In Kansas alone approximately 250,000 beneficiaries have some form of Medicare prescription drug coverage and satisfaction with the program is high.**

- **One reason is cost. Nationally, the average monthly premium for basic benefits is around $25 – which is about 40% below the original projections.**

- **In Kansas, the lowest monthly plan premium is just $14.90 and seven plans have premiums below $25 per month.**

- **In Kansas, 27 of the 52 available plans offer enhanced benefits such as coverage in the donut hole or reduced deductibles.**

- **Within the mix of available plans there are 17 national plans that provide drug coverage in all 50 states which is helpful to the increasingly mobile Medicare population.**

- **Overall, Medicare prescription drug coverage is more comprehensive and less expensive in 2008.**

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Medicare Contracting Reform

- **The Medicare Prescription Drug Improvement and Modernization Act of 2003 directed that Medicare Parts A and B claims processing be integrated onto a single entity to increase efficiency, payment accuracy, and enhance overall customer service.**

- **Hence, Medicare Administrative Contractors (MACs) will perform the work of fiscal intermediaries and carriers.**

- **The process of transitioning to the new MAC contractors is now underway in 15 geographic jurisdictions across the country.**

- **The new MAC contracts were competitively bid and performance based under Federal Acquisition Rules.**

- **On September 5, 2007, CMS announced that Wisconsin Physicians Service Health Insurance Corporation (WPS) had been awarded the contract for processing the Part A and Part B claims for Jurisdiction 5 (J-5) which includes the states of Kansas, Iowa, Missouri and Nebraska.**

- **The single J-5 contract with Wisconsin Physicians Service will replace the contracts with 7 organizations that have been handling Part A and B claims in this region – including that of Blue Cross and Blue Shield of Kansas.**

- **The new contractor (WPS) will serve as the single point of contact for physicians and providers for all claims-related business.**

- **The transition of business operations from these 7 organizations to Wisconsin Physicians Services is to be completed by September 9th of 2008.**

DMEPOS Competitive Bidding Demonstration Program

- **Program goals: diminishing fraud and abuse, enhancing payment accuracy, ensuring patient access, promote quality, achieve savings and better value for beneficiaries and tax payers.**
- **Round I (2007) for 10 MSAs -- Kansas City**

- **Round II (2008) for 70 MSAs – Wichita and Omaha/Council Bluffs**

- **Accreditation Features for DMEPOS suppliers (prior to bidding).**

- **Small Supplier Protections (30%)**

- **Specific product categories: wheel chairs, oxygen supplies, hospital beds, negative pressure wound therapy devices walkers.**

- **Estimated annul savings of $1 billion when fully implemented**

CMS Quality Initiatives (PQRI, POA, EHR)

- **Second year of the Physician Quality Reporting Initiative**
  - **Expansion of reportable measures 74 – 119**
  - **1.5% bonus for successful reporting**
  - **Confidential feedback and comparison to peers.**

- **Leading to a pay for performance (P4P) reimbursement system?**

- **Present on Admission (POA) Program where Medicare will no longer pay for hospital acquired illnesses or conditions.**

- **Electronic Health Records (EHR) grants**