Approved: April 2, 2008
Date

MINUTES OF THE SENATE HEALTH CARE STRATEGIES COMMITTEE

The meeting was called to order by Chairperson Susan Wagle at 1:30 P.M. on February 18, 2008 in Room 136-N of the Capitol.

Committee members absent:

Committee staff present: Ms. Emalene Correll, Kansas Legislative Research Department
Mrs. Terri Weber, Kansas Legislative Research Department
Ms. Nobuko Folmsbee, Revisor of Statutes Office
Ms. Renae Jefferies, Revisor of Statutes Office
Ms. Margaret Cianciarulo, Committee Secretary

Conferees appearing before the committee: Mr. Roderick Bremby, Secretary,
Kansas Department of Health & Environment
Dr. Andy Allison, Deputy Director,
Kansas Health Policy Authority
Dr. Michael Kennedy, President, \
Kansas Academy of Family Physicians
Ms. Corrie Edwards, Kansas Health Consumer Coalition
Ms. Lisa Benlon, American Cancer Society
Father Matthew Cobb, Rector ,
St. Luke's Episcopal Church, Wamego, Kansas
Ms. Cathy Harding, Executive Director,
Kansas Association for Medically Underserved
Mr. Tom Bryon, Kansas Association of Health Underwriters
Mr. Tim Witsman, President,
Wichita Independent Business Association

Others in attendance: Please see attached Guest List

Hearing on SB541 - An act concerning the Kansas Health Policy Authority, relating to powers and duties thereof regarding a medical home, and small business, wellness grant program; establishing the health reform fund.

Upon calling the meeting to order, the Chair asked Ms. Renae Jefferies, Revisor of Statutes Office, to give an overview of the bill. Ms. Jefferies stated that :

- this bill amends and creates statutes concerning the Kansas Health Policy Authority (KHPA)..

- Section 1 increases the voting on nonvoting, ex officio membership to eight with the addition of the commissioner of education as a member of the authority.

- New Section 2 provides that the authority incorporates the use of medical home delivery system within: the Kansas program of medical assistance, the health benefits program for children, and the state mediKan program, all established under Title XIX of the federal social security act. Additionally, the state employees health care commission is to incorporate the use of a medical home delivery system within the state health care benefits program.

- New Section 3 mandates the authority establish a small business wellness grant program, develop a community grant program and provide start-up funds, but the provisions of this section shall expire and the program shall be abolished December 30, 2016.

- Section 4 - amends K.S.A. 75-7408 to include childless adults age 19 and above and under 100% of the federal poverty level under the premium assistance plan effective July 1, 2011, subject to appropriations and other eligibility requirements.

- New Section 5 establishes the health reform fund in the state treasury for the purpose of funding the small business wellness grant program and other health reform options of the authority.

The fund will be administered by the authority and the monies in the fund shall not be used to replace or substitute for moneys appropriated from the state general fund in the immediate proceeding fiscal year. A copy of Ms. Jefferies' overview is (Attachment 1) attached hereto and incorporated into the Minutes by reference..

As there were no questions of Ms. Jefferies, the Chair then called upon the first of seven proponents, Mr. Roderick Bremby, Secretary, Kansas Department of Health and Environment, who also participates as a non-voting ex-officio member of the KHPA, stated that KDHE can offer expertise and experience in establishing the small business wellness grant program described in Section 3. He went on to state that since 2006, the Office of Health Promotion staff have been engaged in a bi-state project with the Missouri Department of Health and Senior Services and the Mid-America Coalition on Health Care in designing and Implementing a Community Initiative on Cardiovascular Health and Disease (CIVC) in conjunction with a group of employees in the Kansas City area. A copy of Secretary Bremby's testimony is (Attachment 2) attached hereto and incorporated into the Minutes by reference.

Second to testify was Dr. Andrew Allison, Deputy Director, Kansas Health Policy Authority who offered a detailed explanation of the bill components and the justification for inclusion into the bill. A copy of his testimony and attachments including: "KHPA Board Health Reform Recommendations (updated January 10, 2008)", a spreadsheet regarding "Estimated Costs of Health Reform Proposals and SB11 (Premium Assistance Kansas Healthy Choices)", "KHPA Board Health Reform Bill Descriptions", "Components of KHPA Health Reform FY 2009," and a "Bill Guide for Health Reform Recommendations" are (Attachment 3) attached hereto and incorporated into the Minutes by reference..

The Chair referred the Committee to three handouts which included: the "2008 Federal Poverty Guidelines", the "Medical Income Eligibility as a Percent of Federal Poverty Level" from the Kaiser Commission on Medicaid and the Uninsured, and a copy of the "Medicaid Enrollment as a Percent of Total Population, 2004" and are (Attachment 4) attached hereto and incorporated into the Minutes by reference

The Chair asked Mr. Allison if he had received an updated fiscal note? He responded he did not have the budget divisions new fiscal note but had received an updated estimate they provided that he believes is the basis for that change.

The Chair then recognized Dr. Michael Kennedy, President, Kansas Academy of Family Physicians (KAPP) who urged the Committee to support the bill with an amendment to include the following definition of the medical home:

"The State of Kansas shall develop and implement the medical home to provide comprehensive primary health care for its citizens, as outlined in the document "Joint Principles of the Patient-Centered Medical Home." and,

"The medical home is a physician-directed medical practice utilizing a team approach with a whole-person orientation, providing accessible, continuous and comprehensive care, to coordinate patients' needs across the health care system, and improve quality and health outcomes in a cost effective manner."

Lastly, he offered two attachments: "Joint Principles of the Patient-Centered Medical Home", February, 2007 from the AAP AAFP, ACP, and AOA, and "The Council of State Governments Resolution on the Patient-Centered Medical Home. A copy of Dr. Kennedy's testimony and attachments are (Attachment 5) attached hereto and incorporated into the Minutes by reference..

Next to testify was Mr. Jerry Slaughter, Executive Director, Kansas Medical Society, who stated that the KHPA developed its recommendations within the context of three core principles which it utilized to

guide its efforts . He went on to say that these three principles -: 1) promoting personal responsibility, 2) promoting a medical home and prevention, and 3) providing and protecting affordable health insurance - represent a solid foundation upon which comprehensive health reform can be built in Kansas. A copy of Mr. Slaughter's testimony is (Attachment 6) attached hereto and incorporated into the Minutes by reference..

The next conferee was Ms. Corrie Edwards, Executive Director, Kansas Health Consumer Coalition (KHCC) based in Topeka, who briefly stated she would like to encourage language in the "medical home" that allowed flexibility components. A copy of her testimony is (Attachment 7) attached.

The Chair then called on Reverend Matthew Cobb, St. Luke's Episcopal Church and Chaplain for Mercy Regional Health Center in Manhattan, but is before the Committee today as a member of the Kansas Faith Alliance for Health Reform. stated that since time was short, he would just offer his testimony. A copy of his testimony is (Attachment 8) attached hereto and incorporated into the Minutes by reference.

The next conferee was Ms. Lisa Benlon, Legislative/Government Relations Director, American Cancer Society, who briefly stated this bill's "medical home" framework for action gives them the important tools needed to work at the front end to find health care solutions Her testimony mentions The American Cancer Society recently underwriting a significant national public awareness campaign related to the problem people have finding quality cancer care as many uninsured and under insured often do not realize their problem until they are confronted with a serious cancer diagnosis and "Medical Homes help to manage these chronic conditions and reduce spending in emergency rooms." A copy of Ms. Benlon's testimony is (Attachment 9) attached hereto and incorporated into the Minutes by reference..

Ms. Cathy Harding, Executive Director, Kansas Association for the Medically Underserved, who stated KAMU supports all of the components of this bill but is most supportive of the medical home concept. She went on to say that the definition of medical home focuses on the system of care rather than on the specific type of practice or provider and allows for flexible systems of care that can be designed to meet the needs of all Kansans in their own communities, including the most vulnerable citizens who are challenged to access needed health care services. A copy of Ms. Harding's testimony is (Attachment 10) attached hereto and incorporated into the Minutes by reference.

As their were no more proponent conferees the Chair offered written testimony as follows:

1. Mr. Chad Austin, Vice President, Government Relations, Kansas Hospital Association.

2. Ms. Leslie Kaufman, Executive Director, Kansas Cooperative Council.

3. Ms. Linda De Coursey, Senior Advocacy Director, Kansas American Heart Association.

4. Ms. Mary Jayne Hellebust, Director, Tobacco Free Kansas Coalition

5. Ms. Terri Roberts, Executive director, Kansas State Nurses Association

A copy of these five testimonies is (Attachment 11) attached hereto and incorporated into the Minutes by reference..

The Chair then called upon the only opponent, Mr. Tom Bryon, Sr., Chairman, Kansas Association of Health Underwriters (KAHU) Legislative Affairs Committee. who commended the health Policy Authority for their efforts and urges them and the Legislature to consider creating incentives for health care providers to make investments in automating their offices and patient records. He went on to say that their primary concerns about the bill are found in Section 4 authorizing and expanding the Premium Assistance program stating the major shortcoming of the current Kansas Premium Assistance program is that it merely funds another state run entitlement program instead of helping uninsured

Kansans purchase health insurance in the competitive market place. He concluded by asking that the Florida Medicaid Reform program be considered a model for Kansas. A copy of his testimony is (Attachment 12) attached hereto and incorporated into the Minutes by reference.

Regarding the Florida Medicaid Reform program, questions were asked of Mr. Bryon from Chairperson Wagle including: :

- Are you saying Florida passed a two-county pilot program?

- Were you saying there were 136 individuals in Broward County and 88,000 in Duval County, and are they a 60-40 mesh?

As there were no more opponents, the Chair then called upon Mr. Tim Witsman, who represented the Wichita Independent Business Association and the Kansas Independent Business Coalition, who stated there is evidence that have a "medical home" improves the quality of care and decreases the cost of health care, however, consumers, physicians, and insurance companies need to be educated and there is also a need to change the current culture of how medical care is delivered. He went on to state that their interest and the value that they see in a "medical home" does not convince them that state government is the most qualified force to lead and control such an effort and this also holds true when the Legislature considers the concept of a premium assistance program currently being offered by the KHPA. A copy of his neutral testimony is (Attachment 13) attached hereto and incorporated into the Minutes by reference.

Committee discussion included questions from Senators Barnett, Wagle and Palmer including:

- re: premium assistance in Florida, a review of the programs were looked at through the Health Policy Oversight Committee during the interim, and dialogue needs to happen about what is going on in other states, particularly Florida, from the standpoint of how successful the program is and more of the details as to why they did not choose that kind of plan. Dr. Barnett would like to hear from Dr. Allison, Ms. Gina Maree, from the Kansas Health Institute, and Mr. Tom Bryon, maybe have a triangular discussion.

Chairperson Wagle asked Dr. Allison, Ms. Maree, and Mr. Bryon if they would be available to come back tomorrow and further discuss programs in other states. As two were available and one would send a representative, the Chair announced to the Committee that she would like to meet tomorrow to discuss this bill and premium assistance. She went on to say that two sheets had been passed out earlier regarding what the poverty guidelines are and how the different states compared and hearing Kansas is on the bottom 5 in the nation, my questions would be why you chose that as opposed to increasing medicaid? She stated, today two plans were discussed, Florida and North Carolina:

- regarding North Carolina, 39% of the non-working individuals are covered, a little higher than the Kansas federal poverty level and 54% of the working persons are covered;

- regarding Florida, 22% non-working and 58% if working are covered. So, Chairperson Wagle asked, why are you saying the program in Florida must be for be for people above 22% at poverty?

Other questions included:

- open policy

- is the fiscal note quite a bit lower?

- re: promoting medical homes, is this a separate budgetary request?

- how is the "medical home" different as to what we have now? What is the concept difference? What would be the increase fee? And, how would other doctor's feel about changing practices?

Adjournment

As it was close to Senate session, the meeting adjourned. The time was 2:35 p.m.

The next meeting is scheduled for February 19, 2008.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

5th in att.

DATE: Monday, February 18, 2008

NAME	REPRESENTING
Mike Sweeden	KHI News
F. Tim Witsman	WIBA/KIBC
Bob Williams	Ks. Assoc. Osteopathic Medicine
Jay Rogers	Ks Ins. Dept.
Katie Fitzgerald	Kearney and Associates
Leslie Kaufman	Ks Cooperative Council
Tom Bryon	Ks Ass of Health Underwriters
Ron Gaches	KAHC
Kathleen Ouellon	KSNA
Dave Heinemann	Am Cancer Society
Connie Edwards	Ks Health Consumer Coalition
Jess Freiser	Ks Optometric Assoc
Kerri Spielman	KAIA
Suzanne Wikle	KS Action for Children
Cheryl Dillard	Coventry Health Care
Peggy Galvin	BCBSKC
Michelle Peterson	Capitol Strategies
Chad Austin	KHA
Dodie Wellshear	Ks Academy of Family Physicians

please pass on after you have signed this - Thx - 57 in att

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: _____

NAME	REPRESENTING
Jeffrey SLAUGHTER	KAHS
Carla Kennedy	
Michael Kennedy, MD	KAFP
Cathy Harding	KAMU
Cynthia Smith	SCL Health System
Pastor [illegible]	Faith Alliance
Carolyn Smith	VCHS
Austin Hayden	Hein Law Firm
Barbara Gibson	KDHE
Michael Massey	KS. Faith Alliance
Gina Maree	KHI
Tatiana Lin	KHI
Natalie Bright	WIBA
Dan Murray	Federico Consulting
LISA BENLON	AMER CANCER SOCIETY
[illegible]	
Susan Mac	ICT TE
Reagan Cussimanio	KHPA

Office of Revisor of Statutes
300 S.W. 10th Avenue
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MEMORANDUM

To: Senate Committee on Health Care Strategies

From: Renae Jefferies, Assistant Revisor

Date: February 18, 2008

Subject: Senate Bill No. 541

SB 541 amends and creates statutes concerning the Kansas Health Policy Authority (Authority).

Section 1 amends K.S.A. 75-7401 by increasing the Authority's nonvoting, ex officio membership to eight with the addition of the commissioner of education as a member of the Authority.

New section 2 provides that the Authority incorporate the use of the medical home delivery system within the Kansas program of medical assistance established under Title XIX of the federal social security act; the health benefits program for children established under K.S.A. 38-2001 et seq. and Title XXI of the federal social security act and the state mediKan program. Additionally, the state employees health care commission is to incorporate the use of the medical home delivery system within the state health care benefits program.

"Medical home" is defined as "a health care delivery system that is person centered and family centered, providing accessible and continuous evidence-based comprehensive, preventive and coordinated health care guided by a personal primary care provider who coordinates and facilitates preventive and primary care to improve health outcomes in an efficient and cost-effective manner."

The Authority in conjunction with the Department of Health and Environment and state stakeholders shall develop systems and standards for the implementation and administration of a medical home on or before February 1, 2009.

New section 3 mandates that the Authority establish a small business wellness grant

program under which the Authority shall develop a community grant program to provide technical assistance to small businesses to assist in the development of workplace wellness programs and provide start-up funds to small businesses to assist in the development of workplace wellness programs. The provisions of this section expire on December 30, 2016.

Section 4 amends K.S.A. 75-7408 to include childless adults age 19 and above, at and under 100% of the federal poverty level, under the premium assistance plans effective July 1, 2011, subject to appropriations and other eligibility requirements.

New section 5 establishes the health reform fund in the state treasury for the purpose of funding the small business wellness grant program and other health reform options of the Authority. The fund will be administered by the Authority. Moneys in the fund may not be used to replace or substitute for moneys appropriated from the state general fund in the immediate preceding fiscal year.

provide life-saving colorectal cancer screening to 12,500 eligible Kansas adults and prostate cancer screening to 6,000 men determined to be at risk for the disease.

Thank you for your consideration of this important step towards health reform in Kansas. I will be pleased to stand for any questions you might have.

KANSAS
DEPARTMENT OF HEALTH
AND ENVIRONMENT

Kathleen Sebelius, Governor
Roderick L. Bremby, Secretary

www.kdheks.gov

Testimony on SB 541

To
Senate Health Care Strategies Committee

Presented by
Roderick L. Bremby
Secretary
Kansas Department of Health and Environment

February 18, 2008

Chairperson Wagle and members of the Committee, my name is Roderick Bremby. I serve as Secretary of the Kansas Department of Health and Environment and am very pleased to appear before you today in support of SB541 which proposes to implement health reform recommendations proposed by the Kansas Health Policy Authority.

As Secretary of KDHE, I participate as a non-voting ex-officio member of the Kansas Health Policy Authority. In that role I have had the opportunity, along with the other Board members, to hear directly from consumers, medical providers and payers related to the health care crisis we are facing. I am impressed with the due diligence of the process facilitated by KHPA in reaching a consensus set of 21 recommendations to begin the health reform process in Kansas. Input to the process was extensive, with more than 1000 individuals and organizations involved in the discussions throughout the past year.

Health care expenditures in the United States have grown at slightly more than twice the pace of the national gross domestic product (GDP) in recent years. Between 1980 and 2010, the portion of the nation's GDP spent on health is projected to roughly double. Simultaneously, public funds are paying for a larger share of these costs through Medicaid, Medicare and other publicly funded programs. This means that every year, health care costs will consume more and more public funds, leaving less funding for other needed programs.

Until recently, state policy makers have tried to control rising health care costs primarily through cost-containment measures. Now, however, states are paying more attention to the root causes of skyrocketing medical expenditures. Costly, debilitating and preventable chronic diseases are among the key contributors to the increased costs states

face. Without aggressive intervention into the root causes of these chronic diseases and their costs, these trends are expected to continue to worsen.

SB541 speaks to reforms related specifically to the operation of the Kansas Health Policy Authority. First, it proposes to add the Commissioner of Education to the Board as a non-voting, ex officio member. This is an important addition towards assuring that the KHPA's mission to establish a healthy future for our children is fulfilled. The Commissioner of Education serves as a vital link to implementation of health reforms that relate to child health and is an addition that is strongly supported by KDHE.

SB541 also proposes a statutory definition for medical homes as a first step to providing a model of care for Kansans that addresses a long-term solution for health care costs for the state of Kansas. KDHE's Office of Local and Rural Health offers a great deal of experience in health systems development, particularly as it relates to primary care. Our agency staff stands ready to work with the KHPA to assure systems and standards that maximize the resources currently in place, particularly as they impact the primary care providers who serve our most vulnerable Kansans.

Similarly, KDHE staff can offer expertise and experience in establishing the small business wellness grant program described in Section 3. Since 2006, the Office of Health Promotion staff have been engaged in a bi-state project with the Missouri Department of Health and Senior Services and the Mid-America Coalition on Health Care in designing and implementing a Community Initiative on Cardiovascular Health and Disease (CIVC) in conjunction with a group of employers in the Kansas City area. The initiative focuses on employer leadership to address cardiovascular health risk factors not only in the work site, but also in the clinical and community environments. In 2008, the employers will continue their work site interventions and begin to address aligning their benefit programs around health and cost outcomes. The "lessons learned" from this initiative can provide valuable insight into the development of the small business wellness grants program.

New Section 5 establishes a health care reform fund to be administered by the KHPA for funding the small business wellness grant program and for other health reform options of the KHPA. These appropriation requests include dental coverage for pregnant Medicaid beneficiaries, providing tobacco cessation support for Medicaid beneficiaries, expanding health care for Kansas children and young adults, supporting coordinated school health programs to increase physical fitness of children and improving access to cancer screening. KDHE supports the use of the health care fund for these purposes as an effective first step in beginning to address the root causes of escalating health care costs. The allocation for coordinated school health, for example, supports an evidence-based approach to creating healthy school environments that foster development of lifelong healthy behaviors, which promise major gains in the fight against obesity and tobacco related diseases. The cancer screening recommendation will enable the "Early Detection Works" breast and cervical cancer program to return to the 2006 screening level of serving approximately 7,000 income and age eligible women. Additionally, it will

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KANSAS HEALTH POLICY AUTHORITY

Testimony on:
SB 541: KHPA Health Reform

Presented to:
Senate Health Care Strategies

By:
Andrew Allison, PhD
Deputy Director
Kansas Health Policy Authority

February 18, 2008

For additional information contact:

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Testimony to the Senate Health Care Strategies Committee
February 18, 2008

SB 541: KHPA Health Reforms
Andrew Allison, PhD, Deputy Director, Kansas Health Policy Authority

Good afternoon Madam Chair and Committee members. I am Andy Allison, Deputy Director of the Kansas Health Policy Authority (KHPA). Thank you for the opportunity to address the Senate Health Care Strategies Committee on the KHPA's health reform bill, SB 541. The following testimony is a detailed explanation of the bill components and the justification for inclusion into the bill.

Section 1: Adding Commissioner of Education to KHPA Board. This section adds the Commissioner of Education to the KHPA Board as a non-voting ex officio member. The KHPA Board understands the importance of promoting healthy behaviors at an early age and the addition of the Commissioner of Education will provide a source of knowledge for the implementation of any school programs.

KHPA Board Description:
The KHPA Board is comprised of nine appointed voting members and seven ex-officio members representing government agencies with critical roles in the promotion and development of health care policies, administration of health care programs, and resources throughout Kansas. Inclusion of the education community in fulfilling this mission is essential to establishing a healthy future for our children. From an implementation perspective, the KHPA Board does not have the authority to implement this addition and should make known its intention to the Legislature due to the statutory origin of the KHPA.

Need for Commissioner of Education on KHPA Board:
We develop many of our health habits as children. One of the central focus areas in these reforms is encouraging healthy behaviors in schools. Specifically, the reforms address school lunches, vending machines, and physical education. The Kansas Commissioner of Education could provide expert advice on implementing these initiatives to achieve success.

Legislative Action: Statutory change is necessary to add the Education Commissioner to the KHPA board.

Section 2: Medical Home Definition. This section sets out a framework for defining a medical home in Kansas for state-funded health programs in order to increase care coordination, improve health outcomes, and decrease health care costs.

Medical Home Description:
One of the components of Kansas health reform is to promote a person-centered medical home as a way to improve the quality of primary health care, promote improved health status, and ultimately help to control the rising costs of health care. The designation of the medical home is a cornerstone of support for other areas of the KHPA preventive health agenda. Defining in statute the meaning of a medical home in Kansas will provide the framework for further development and implementation of a medical home model.

Need for Medical Homes:
Promoting the development and use of medical home practices will help to organize health care services through a medical home model with the goal of improving health outcomes and containing health care costs. States, such as Colorado, Washington, Missouri, and Louisiana, are advancing the medical home model and passing legislation to organize Medicaid programs around the medical home concept. North Carolina has used existing legislative authority to extend the medical home concept to its Medicaid and State Children's

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ıealth Insurance Program (SCHIP) populations. A number of states have defined a medical home in . .e, such as Louisiana, Colorado, and Massachusetts.

A "Medical Home" refers to a model of health care delivery that is person centered and family centered, providing accessible and continuous evidence-based, comprehensive, preventive and coordinated health care guided by a personal primary care provider who coordinates and facilitates preventive and primary care to improve health outcomes in an efficient and cost effective manner.

Because our health system is so fragmented – with patients, providers, and purchasers operating under a different set of financial incentives – health care costs in Kansas and across the United States continue to rise at an unsustainable rate. Indeed, we pay double per capita compared to any other industrialized country in the world, but with far worse health outcomes. A medical home model of health care places at the center of our health system the consumer-provider relationship, improved overall health status, and increased personal responsibility for our health.

Legislative Action: This legislation directs the Kansas Medicaid/HealthWave programs and State Employee Health Plan to work with stakeholders on developing measures and standards for a medical home in Kansas. *There is no associated fiscal note.*

Section 3: Small Business Wellness Program. This section establishes within the Kansas Health Policy Authority a small business wellness grant program. The purpose of this section is to develop a community grant program that provides technical assistance and funds to assist small businesses in establishing wellness programs for their employees.

Workplace Wellness Program Description:
Large employers have frequently embraced workplace wellness programs as mechanisms to improve employee health, decrease absenteeism, and enhance productivity. The costs of starting such programs are prohibitive for small employers who often do not have adequate resources and economies of scale to pay for these kinds of programs. The component of "personal responsibility" within health care reform encompasses not only individual choice, but establishing an environment which facilitates the choice for health. Workplace wellness programs embody this strategy.

Need for Small Business Wellness Program:
Well-designed worksite health interventions can have an enormous impact on disease prevention and control, resulting in significant savings in health care spending, improved presenteeism, and increased productivity. A comprehensive worksite wellness program consists of health education, supportive social and physical environments, integration of programs into the organizational structure, linkage to related programs such as employee assistance programs (EAP), and screening programs linking to health care. Comprehensive worksite health promotion programs can yield a $3 to $6 return on investment (ROI) for every dollar spent over a 2–5 year period. Worksite health promotion programs can reduce absenteeism, health care, and disability workers' compensation costs by more than 25% each.

Over 80% of businesses with over 50 employees have some form of health/wellness programs, but they are much less available in small businesses. Small businesses have limited resources and their lack of staff, budget, and wellness knowledge are barriers to providing wellness programs. Once established, however those wellness programs are quite economical costing $30-$200 per employee per year.

Legislative Action: $100,000 SGF appropriation.

Section 4: Expansion of Premium Assistance. This section expands on the premium assistance program passed in SB 11 – slated to begin January 2009 – to include low income adults without children. Premium Assistance, called Kansas Healthy Choices, is a new health insurance program that provides private health insurance to very low income Kansas families. After full phase in of the premium assistance for low income families up to 100% of the Federal Poverty Level (in FY 2011), childless adults under 100% of poverty (about $10,700 in 2007) will be eligible to participate (in FY 2012).

Premium Assistance Description:
Premium assistance is the use of public, employer, and potentially individual contributions to purchase private health insurance for Kansas families living in poverty who cannot otherwise afford coverage. Since passage of SB 11 in May 2007, KHPA has engaged in an extended, open, and participatory process to complete the program design and implementation of the premium assistance program **Kansas Healthy Choices**. The program will be implemented in January 2009. The premium assistance expansion to is to open Kansas Healthy Choices up to low-income childless (i.e., adults who have no children) adults who make less than 100% of the Federal Poverty Level ($10,210 annually). Program implementation for this expansion will be for FY 2012.

Need for Premium Assistance:

- **Saves money.** The purchase of private insurance through Kansas Healthy Choices helps control state health care spending for the poverty level population by providing broader access to preventive care, and strengthens and expands private markets, rather than replacing or eliminating them.
- **Prudently partners with other funding resources.** This program ensures state access to 60% Federal matching funds. In addition, this wrap-around assistance strategically relies on employer contributions when available.
- **Unites families in health care.** Kansas Healthy Choices provides coverage for each member of the family under one plan, strengthening a family culture of prevention, health literacy, and care.
- **Breaks a vicious cycle.** Those without insurance use fewer preventive and screening services, are sicker when diagnosed, receive fewer therapeutic services and have poorer health outcomes in terms of mortality and disability rates. In addition, this group has lower earnings due to poor health.
- **Makes an impact.** Over the next three years, Kansas Healthy Choices is expected to provide about 20,000 existing and 24,500 newly eligible caretaker adults and their children with the choice of private insurance options and a "medical home" model of health care services.

Kansas Healthy Choices is an effective, prudent use of public funds to save public dollars in the long-term, strengthen private insurance markets, and improve the quality of life and access to health care for thousands of Kansas families. Supporting Kansas Healthy Choices means providing a smart path to private insurance for individuals and families who would otherwise be unable to obtain health insurance coverage on their own.

Population Served: Around 39,000 low-income Kansan adults without children would become newly insured.

Legislative Action: Statutory change to expand premium assistance eligibility; no state funding required until FY 2012 - $26 Million SGF.

...on 5: Creating the Health Reform Fund. This section creates a "Health Reform Fund" within the ... treasury. Revenues from a proposed increase in the state tobacco user fee will be deposited in the interest bearing fund and the funds will be utilized solely to pay for health reforms.

Referenced in SB 542, Section 8:
This section creates the new Health Reform fund within the state treasury with the Kansas Health Policy Authority or its designee approving vouchers from the fund. The section also requires certain transfers to be made out of the State General Fund to the Health Reform Fund with $61.57 million in 2009, $68.62 million in 2010, $68.24 million in 2011, $67.8 million in 2013, and $66.95 million in 2014. With the revenue generated from the cigarette and smokeless tobacco tax going directly into the State General Fund this section requires only the amount needed for health reform to actually be placed within the Health Reform fund. Therefore, if the tobacco tax takes in more than expected the State General Fund will reap the benefits and not the Health Reform Fund.

Need for Health Reform Fund:
It is imperative that health reform have its own interest bearing trust fund in order to adjust for changes in the health care market place and so that its funding does not take away from other public programs.

Legislative Action: Statutory change is necessary to create the interest bearing health reform trust fund.

Conclusions: The KHPA Board urges the Committee to pass SB 541 in order to make improvements in Kansas' health and health care system by focusing prevention efforts in schools and workplaces, improving coordination and patient-centered care, and increasing access to affordable health insurance coverage for low-income Kansans.

3-5

Kansas Health Policy Authority Board

Health Reform Recommendations

UPDATED

January 10, 2008

PREPARED BY:

KHPA
Kansas Health Policy Authority
Coordinating health & health care for a thriving Kansas

3-6

Executive Summary

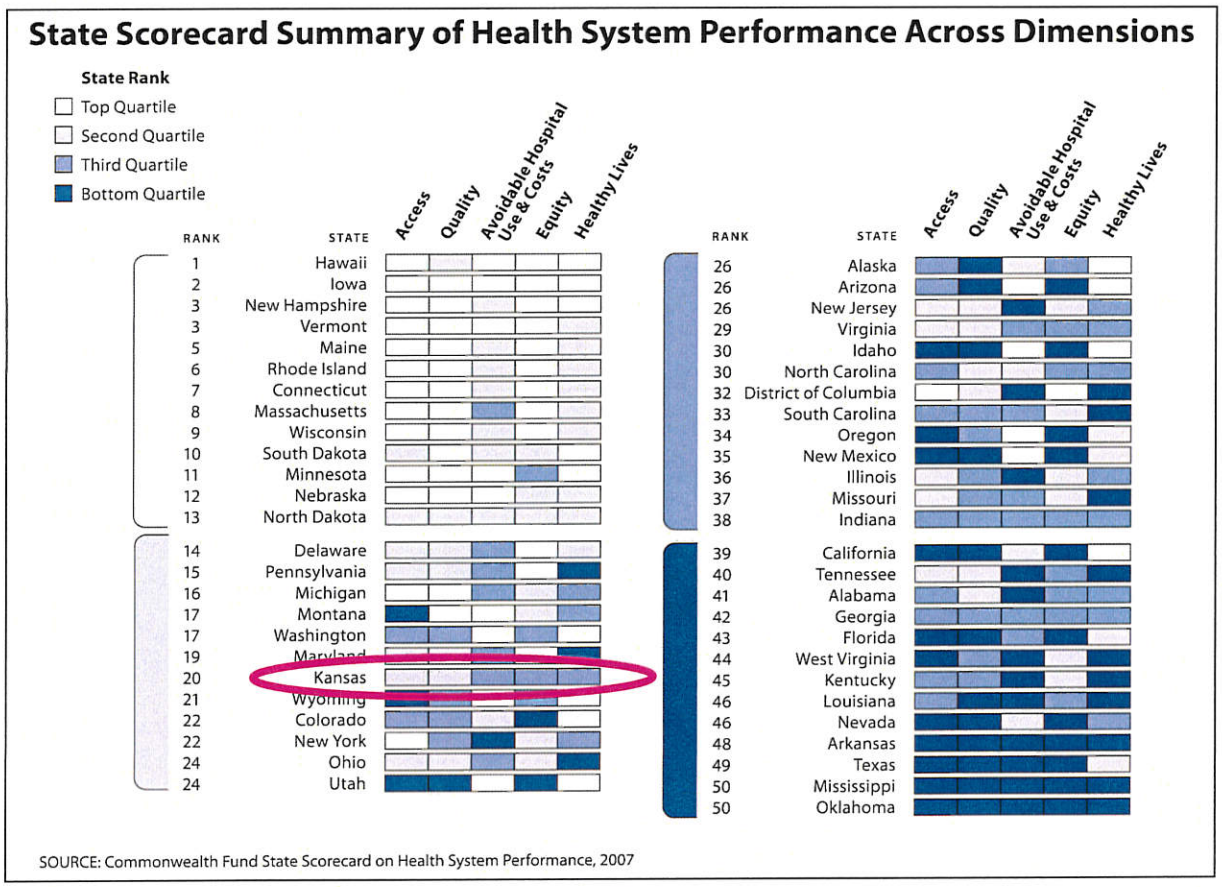
Background

The current health system in Kansas and the nation face many challenges. Health care costs continue to rise at an unsustainable rate, the health system is inefficient and fragmented, and the health status of many Kansans is at risk. From the perspective of health system performance, Kansas currently ranks 20th in the nation[1] – we can and should do better (Figure 1). The goals of the health reform recommendations described in this report are twofold: 1) to begin the *transformation* of our underlying health system in order to address the staggering rise in health care costs and chronic disease, as well as the underinvestment in the coordination of health care; and 2) to provide Kansans in need with affordable access to health insurance. Taken together, these reforms lay out a meaningful first step on the road to improve the health of Kansans, and we respectfully submit them to the Governor and Legislature for their consideration.

These health reform recommendations were requested by both the Governor and the Legislature. During the 2007 legislative session, the Kansas Legislature passed House Substitute for Senate Bill 11 (SB 11), which included a number of health reform initiatives. This Bill passed unanimously by both the House and Senate, and was signed into law by the Governor. In addition to creating a new "Premium Assistance program" to expand access to private health insurance, the Bill directed the Kansas Health Policy Authority (KHPA) to develop health reform options in collaboration with Kansas stakeholders.

The health reform recommendations described herein are the result of deliberations of the KHPA Board, four Advisory Councils (140 members), a 22 community listening tour, and feedback from numerous stakeholder groups and other concerned citizens of Kansas – over 1,000 Kansans provided us with their

Figure 1



SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

*For more information about the Study, go to http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=494551

advice and suggestions. In addition, four Kansas foundations – the United Methodist Health Ministry, the Sunflower Foundation, the REACH Foundation, and the Health Care Foundation of Greater Kansas City – funded an independent actuarial and policy analysis of various health insurance models as well as the coordination of the four Advisory Councils. The modeling was instrumental in the development of the health insurance recommendations offered by the KHPA Board, and a separate document describing these models is available through the United Methodist Health Ministry Fund (www.healthfund.org).

These health reform recommendations represent just one of the many chapters required to write the story of improved health and health care in Kansas. Ultimately, the solution for our fragmented health system requires leadership at the federal level. However, the state of Kansas should debate and embrace reform solutions that can help our citizens right now. Additional policy issues – such as health professions workforce development, and a focus on the safety and quality of care – must also be addressed in subsequent health reform proposals over the course of the coming months and years.

PRIORITIES

Kansas established three priorities for health reform:

1) ***Promoting Personal Responsibility*** – for healthy behaviors, informed use of health care services, and sharing financial responsibility for the cost of health care;
2) ***Promoting Medical Homes and Paying for Prevention*** – to improve the coordination of health care services, prevent disease before it starts, and contain the rising costs of health care; and
3) ***Providing and Protecting Affordable Health Insurance*** – to help those Kansans most in need gain access to affordable health insurance.

The combination of these health reforms helps to improve the health status of Kansans, begins to contain the rising cost of health care in our state, and improves access to affordable health insurance.

The table below outlines the reform priorities recommended by the KHPA Board on November 1, 2007. Those policy initiatives identified as high priority are marked by an asterisk.

SUMMARY OF REFORM RECOMMENDATIONS

Promoting Personal Responsibility (P1)		
Policy Option	**Population Served**	**Estimated Cost**
Improve Health Behaviors. Encourage healthy behaviors by individuals, in families, communities, schools, and workplaces. **(Policies listed under P2)**		
Informed Use of Health Services		
***P1 (1) Transparency for Consumers: Health Care Cost & Quality Transparency Project**. Collect and publicize Kansas specific health care quality and cost information measures which will be developed for use by purchasers and consumers	All Kansans with access to the Internet (or access to public libraries)	$200,000 State General Fund (SGF) for Phase II of the Transparency project
***P1 (2) Promote Health Literacy.** Provide payment incentives to Medicaid/HealthWave providers who adopt health literacy in their practice settings	Medicaid/HealthWave enrollees under care of these providers	$280,000 All Funds (AF) $140,000 SGF for pilot program with Medicaid/ HealthWave providers
Shared Financial Responsibility. Asking all Kansans to contribute to the cost of health care. ***(Policies listed under P3)***		
Estimated Costs for P1	**$480,000 AF $340,000 SGF**	

Promoting Medical Homes and Paying for Prevention (P2)		
Policy Option	**Population Served**	**Estimated Cost**
Promoting Medical Homes		
***P2 (1)Define Medical Home**. Develop statutory/regulatory definition of medical home for state-funded health programs – Medicaid, HealthWave, State Employee Health Plan (SEHP)	Beneficiaries of state-funded health care plans	Planning process should incur minimal costs to KHPA
***P2 (2) An Analysis of and Increase in Medicaid Provider Reimbursement.** Increased Medicaid/HealthWave reimbursement for primary care and prevention services	Beneficiaries and providers in Medicaid and HealthWave programs	$10 million AF; $4 million SGF
P2 (3) Implement Statewide Community Health Record (CHR). Design statewide CHR to promote efficiency, coordination, and exchange of health information for state-funded health programs (Medicaid, HealthWave, SEHP)	Beneficiaries of state-funded health care plans	$1.8 million AF; $892,460 SGF
P2 (4) Promote Insurance Card Standardization. Promote and adopt recommendations from Advanced ID Card Project for state-funded health programs	Kansans who qualify/enrolled in state-funded health care plans	$172,000 AF; $86,000 SGF
Paying for Prevention: Healthy Behaviors in Families/Communities		
***P2 (5) Increase Tobacco User Fee.** Institute an increase in the tobacco user fee $.50 per pack of cigarettes, and an increase in the tax rate of other tobacco products to 57% of wholesale price.	Total Kansas population	Provides revenues of $61.57 million. Dept of Revenue estimate 12/07
***P2 (6) Statewide Restriction on Smoking in Public Places.** Enact statewide smoking ban in public places, couples with Governor's Executive Order requiring state agencies to hold meetings in smoke-free facilities	1.4 million working adults in Kansas	No cost to the state; limited evidence of other cost implications
***P2 (7) Partner with Community Organizations.** Expand the volume of community-based health and wellness programs through partnerships between state agencies and community organizations	All residents and visitors to state of Kansas	Costs dependent upon scope of project (number of organizations)
Paying for Prevention: Healthy Behaviors in Schools		
***P2 (8) Include Commissioner of Education on KHPA Board.** Expand the KHPA Board to include an ex-officio seat for the Kansas Commissioner of Education	Kansas school children	No cost
***P2 (9) Collect Information on Health/Fitness of Kansas School Children.** Support the establishment of a state-based surveillance system to monitor trends of overweight, obesity, and fitness status on all public school-aged children in Kansas	Kansas school children K-12; for 2006-07 year, there were 465,135 enrolled K-12 students	Schools would incur some indirect costs for staff training and body mass index (BMI) measurement

Promoting Medical Homes and Paying for Prevention (P2) (continued)		
Policy Option	**Population Served**	**Estimated Cost**
Paying for Prevention: Healthy Behaviors in Schools		
***P2 (10) Promote Healthy Food Choices in Schools.** Adopt policies that encourage Kansas school children to select healthy food choices by competitively pricing and marketing these foods and restricting access to foods with little or no nutritional value	Kansas school children K-12; for 2006-07 year, there were 465,135 enrolled K-12 students	Depending on pricing policies, implementation of this initiative may reduce or increase the revenue generated
***P2 (11) Increase Physical Fitness and School Health Programs**. Strengthen physical education (PE) requirements and expand Coordinated School Health (CSH) programs	465,135 enrolled K-12 students	$8,500 per participating school. KDHE has requested $1.8 million SGF for the CSH program for participation of 100 districts
Paying for Prevention: Healthy Behaviors in Workplace		
***P2 (12) Wellness Grant Program for Small Business.** Develop a community grant program to provide technical assistance and start-up funds to small businesses to assist them in the development of workplace wellness programs	Kansas employees of small firms	$100,000 SGF for pilot project
***P2 (13) Healthier Food Options for State Employees.** Expand healthy food choices in state agency cafeterias and vending machines	Approximately 45,000 state employees	Costs depend on contract negotiations and pricing policies
Paying for Prevention: Additional Prevention Options		
***P2 (14) Provide Dental Care for Pregnant Women.** Include coverage of dental health services for pregnant women in the Kansas Medicaid program	6,600 Pregnant women enrolled in Medicaid	$1.3 million AF; $524,000 SGF
***P2 (15) Improve Tobacco Cessation within Medicaid.** Improve access to Tobacco Cessation programs in the KS Medicaid program to reduce tobacco use, improve health outcomes, and decrease health care costs	Approximately 84,000 Medicaid beneficiaries who smoke	$500,000 AF; $200,000 SGF for an annual cost
***P2 (16) Expand Cancer Screenings.** Increase screenings for breast, cervical, prostate, and colon cancer through expansion of the Early Detection Works (EDW) program	7,500 women (for Breast/Cervical screenings); 6,100 men (for prostate cancer screening); and 12,000 Kansans (for colorectal cancer screenings)	KDHE has requested $6.7 million SGF for cost of expansion of all three cancer screenings
Estimated Costs for P2	**$22.4 million AF $14.3 million SGF**	

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Providing and Protecting Affordable Health Insurance (P3)		
Policy Option	**Population Served**	**Estimated Cost**
P3 (1) Access to Care for Kansas Children and Young Adults		
• Aggressive targeting and enrollment of children eligible for Medicaid and HealthWave • Include specific targets and timelines for improved enrollment. Inability to meet targets will "trigger" additional action by the KHPA, to include the consideration of mandating that all children in Kansas have health insurance • Allow parents to keep young adults (through age 25 years) on their family insurance plan • Develop Young Adult policies with limited benefit package and lower premiums	Estimated 20,000 Medicaid/HealthWave eligible Estimated 15,000 young adults	$22 million AF $14 million SGF
P3 (2) Expanding Insurance for Low-Income Kansans*		
• Expansion population for the Premium Assistance program ♦ Adults (without children) earning up to $10,210 annually[100% federal poverty level (FPL)]	Estimated 39,000 low income Kansas adults	$119 million AF $ 56 million SGF
P3 (3) Affordable Coverage for Small Businesses		
• Encourage Section 125 plans (develop Section 125 "toolkits") and education campaign for tax-preferred health insurance premiums • Develop a "voluntary health insurance clearinghouse" to provide on-line information about health insurance and Section 125 plans for small businesses and their employees • Add sole proprietors and reinsurance to the very small group market (VSG: one to ten employees). Stabilize and lower health insurance rates for the smallest (and newest) businesses: obtain grant funding for further analysis • Pilot projects – support grant program in the Department of Commerce for small business health insurance innovations	Estimated 12,000 small business owners and their employees (***Note: At the person level, the uncompensated care costs for the previously uninsured are reduced due to this change, hence the reduction in All Funds shown above. Practically, however, at the program level, the State of Kansas will not change the State's Disproportionate Share Hospital reimbursement methodology.)	-$5 million AF*** $1 million SGF
Estimated Costs for P3 Cost of all 3 policy options is:		**$136 million AF** **$ 71 million SGF**
Total Costs		**$158.9 million AF**** **$ 85.7 million SGF** ****(includes federal matching dollars)**

Two additional components of health reform, separate from the policies listed here, are being submitted to the Governor and Legislature as part of the KHPA budget. Funding for each is essential as the "building blocks" of health reform: 1) **Premium Assistance. As designed in SB 11, this request asks for a $5.037 million enhancement ($12.075 AF) for the Premium Assistance program in FY2009; these funds will provide private health insurance to parents of children eligible for Medicaid who earn less than 50% of the FPL (approximately $10,000 for a family of four); and 2) **Web-Based Enrollment System**. The KHPA budget asks for a $4 million enhancement for FY2009 ($8 million AF) to implement a new electronic eligibility system that can support premium assistance, enhanced outreach, and program participation through web-based enrollment.

Estimated Costs of Health Reform Proposals and SB 11 (Premium Assistance: Kansas Healthy Choices)
Detailed Cost Estimate by Principle

	FY 2009		FY 2010		FY 2011		FY 2012		FY 2013	
	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds
Additional Prevention Options										
Provide Dental Care for Pregnant Women.										
Program Cost	$524,000	$1,310,000	$528,000	$1,320,000	$530,000	$1,325,000	$532,000	$1,330,000	$533,600	$1,334,000
Administrative Cost	*									
Improve Tobacco Cessation within Medicaid.										
Program Cost	$200,000	$500,000	$220,000	$550,000	$220,000	$550,000	$220,000	$550,000	$220,000	$550,000
Administrative Cost	*									
Expand Cancer Screenings. In KDHE Budget										
Program Cost	$6,666,939	$6,666,939	$6,966,015	$6,966,015	$7,278,621	$7,278,621	$7,605,371	$7,605,371	$7,946,910	$7,946,910
Administrative Cost	*									
Estimated Costs for P2	**$8,510,267**	**$10,081,867**	**$13,826,756**	**$21,115,234**	**$14,920,769**	**$22,356,978**	**$16,134,216**	**$23,858,455**	**$17,430,224**	**$25,462,864**
*= Unknown Administrative Costs										
Provide and Protect Affordable Health Insurance (P3)										
***Expanding Insurance for Low-Income Kansans**.**										
Program Cost	$--	$--	$--	$--	$--	$--	$26,000,000	$64,000,000	$56,000,000	$140,000,000
Administrative Cost										
***Access to Care for Kansas Children and Young Adults.**										
Aggressive targeting and enrollment of children eligible for Medicaid and										
Program Cost	$1,302,716	$3,431,720	$6,094,690	$15,993,480	$12,567,869	$33,031,950	$18,521,432	$48,678,715	$21,341,890	$56,093,460
Administrative Cost	$850,506	$1,701,011	$860,006	$1,720,012	$877,159	$1,754,318	$894,806	$1,789,612	$912,961	$1,825,921
***Affordable Coverage for Small Businesses.**										
Program Cost	$1,000,000	($5,000,000)	$1,000,000	($5,000,000)	$1,000,000	($5,000,000)	$1,000,000	($5,000,000)	$1,000,000	($5,000,000)
Administrative Cost	*									
Estimated Costs for P3	**$3,153,222**	**$132,731**	**$7,954,696**	**$12,713,492**	**$14,445,028**	**$29,786,268**	**$46,416,238**	**$109,468,327**	**$79,254,851**	**$192,919,381**
Total Costs -- Health Reform Proposals	**$12,003,489**	**$10,694,598**	**$22,121,452**	**$34,308,726**	**$29,755,797**	**$52,673,246**	**$62,890,454**	**$133,806,782**	**$97,050,075**	**$218,912,245**
Tobacco Products User Fee										
Cigarette Tax Increase	$43,140,000		$48,660,000		$48,280,000		$47,840,000		$47,410,000	
Tobacco Products Tax Increase	$18,430,000		$19,960,000		$19,960,000		$19,960,000		$19,960,000	
Interest on the fund balance			$2,898,845		$6,105,488		$6,637,721		$7,160,512	
Premium Assistance										
Concept is approved within SB 11 with required appropriation to fund the anticipated caseload costs.										
Program Cost	$3,757,500	$9,515,000	$14,000,000	$35,000,000	$31,000,000	$77,000,000	$41,000,000	$102,000,000	$45,000,000	$111,000,000
Administrative Cost	$1,280,000	$2,560,000								

2/15/2008
Finance and Operations
Kansas Health Policy Authority

Estimated Costs of Health Reform Proposals and SB 11 (Premium Assistance: Kansas Healthy Choices)
Detailed Cost Estimate by Principle

	FY 2009		FY 2010		FY 2011		FY 2012		FY 2013	
	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds
Promoting Personal Responsibility (P1)										
Improve Health Behaviors.										
Informed Use of Health Services:										
Transparency for Consumers:										
Program Cost	$200,000	$200,000	$200,000	$200,000	$250,000	$250,000	$200,000	$200,000	$200,000	$200,000
Administrative Cost	*									
Promote Health Literacy.										
Program Cost	$140,000	$280,000	$140,000	$280,000	$140,000	$280,000	$140,000	$280,000	$165,000	$330,000
Administrative Cost	*									
Shared Financial Responsibility.										
Estimated costs for P1	**$340,000**	**$480,000**	**$340,000**	**$480,000**	**$390,000**	**$530,000**	**$340,000**	**$480,000**	**$365,000**	**$530,000**
*= Unknown Administrative Costs										
Promoting Medical Homes and Paying for Prevention (P2)										
Promoting Medical Homes										
Define Medical Home.										
An Analysis of and Increase in Medicaid Provider Reimbursement.										
Program Cost			$4,000,000	$10,000,000	$4,076,685	$10,191,712	$4,153,606	$10,384,014	$4,230,570	$10,576,424
Administrative Cost										
Implement Statewide Community Health										
Program Cost	$308,600	$617,200	$337,978	$675,956	$506,971	$1,013,942	$691,489	$1,382,978	$892,460	$1,784,919
Administrative Cost	$75,000	$150,000	$125,000	$250,000						
Promote Insurance Card Standardization.										
Program Cost										
Administrative Cost	$70,000	$172,000	$(203,500)	$(500,000)	$(213,307)	$(524,096)	$(223,512)	$(549,170)	$(230,661)	$(566,735)
Healthy Behaviors in Families/Communities										
Increase Tobacco User Fee.										
Statewide Ban on Smoking in Public Places.										
Partner with Community Organizations.										
Healthy Behaviors in Schools										
Include Commissioner of Education on KHPA Board.										
Collect Information on Health/Fitness of Kansas School Children.										
Promote Healthy Food Choices in Schools.										
Increase Physical Education (PE).										
Program Cost	$550,728	$550,728	$1,753,263	$1,753,263	$2,406,799	$2,406,799	$3,055,262	$3,055,262	$3,737,346	$3,737,346
Administrative Cost	*									
Healthy Behaviors in Workplace										
Wellness Grant Program for Small Business.										
Grant Cost	$100,000	$100,000	$100,000	$100,000	$100,000	$100,000	$100,000	$100,000	$100,000	$100,000
Administrative Cost	$15,000	$15,000			$15,000	$15,000				
Healthier Food Options for State Employees.										

KHPA Board
Health Reform Bill Descriptions

Part I. KHPA Reforms *(SB 541)*

Section 1: Adding Commissioner of Education to KHPA Board. This section adds the Commissioner of Education to the KHPA Board as a non-voting ex officio member. The KHPA Board understands the importance of promoting healthy behaviors at an early age and the addition of the Commissioner of Education will provide a source of knowledge for the implementation of any school programs.

Section 2: Medical Home Definition. This section sets out a framework for defining a medical home in Kansas for state-funded health programs in order to increase care coordination, improve health outcomes, and decrease health care costs.

Section 3: Small Business Wellness Program. This section establishes within the Kansas Health Policy Authority a small business wellness grant program. The purpose of this section is to develop a community grant program that provides technical assistance and funds to assist small businesses in establishing wellness programs for their employees.

Section 4: Expansion of Premium Assistance. This section expands on the premium assistance program passed in SB 11 – slated to begin January 2009 – to include low income adults without children. Premium Assistance, called Kansas Healthy Choices, is a new health insurance program that provides private health insurance to very low income Kansas families. After full phase in of the premium assistance for low income families up to 100% of the Federal Poverty Level (in FY 2011), childless adults under 100% of poverty (about $10,700 in 2007) will be eligible to participate (in FY 2012).

Section 5: Creating the Health Reform Fund. This section creates a "Health Reform Fund" within the State treasury. Revenues from a proposed increase in the state tobacco user fee will be deposited in the interest bearing fund and the funds will be utilized solely to pay for health reforms. (Also referenced in SB 542 Section 8)

Part II. Insurance Reforms *(Bill Number 540)*

Section 1: Establishing Very Small Employer. This section defines and creates a group for very small employers. Very small employers are defined as employers who employ at most 10 employees and includes sole proprietors.

Section 2: Creating Young Adult Policies. This section defines and creates a separate group for young adults for the purposes of health insurance. A young

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adult is defined as an individual who has attained the age of 18 through the age of 25 (under the age of 26). Creating a specific group in insurance law for young adults will lead to creation of more affordable insurance products with benefit packages tailored to the needs of young adults and will expand health insurance access among the 20% of young adults who are uninsured.

Sections 3, 4, & 5: Increasing Age of Dependants on Parent's Health Insurance. These sections amend current insurance law by permitting that parents can keep their children on their insurance plan until the children reach the age of 26, as long as the children are dependents. Allowing individuals who are under the age of 26 to remain on their parent's health insurance policy will reduce the 20% of young adults who are uninsured.

Sections 6, 7, 8, & 9: Creating the Kansas Small Business Health Policy Committee. These sections reorganize the Kansas Business Health Partnership Act (BHP) by (1) establishing the Kansas Small Business Health Policy Committee and (2) removing the subsidy function of the BHP (which was not operational) . The purpose of this new committee is to establish a voluntary health insurance clearinghouse for small businesses to assist with the acquiring of insurance for their employees and accessing cafeteria plans (Section 125 plans) and also analyze the use of reinsurance. The committee will report to the KHPA Board and provide annual reports to the Board and Commissioner of Insurance.

Sections 10 & 11: Transfer Cafeteria Plan Promotion Program from Commerce to KHPA. Sections 10 and 11, moves from the Department of Commerce to the Kansas Health Policy Authority the section 125 cafeteria plan promotion that was established as part of SB 11. The newly created Kansas Small Business Health Policy Committee will direct the cafeteria plan promotion with the goal of encouraging and expanding the use of cafeteria plans.

Part III. Tobacco Fee Assessment ***(Bill Number 542)***

Section 1: Fee Increase on Cigarettes. This section increases the tax on a package of cigarette by $.50 to $1.29, beginning on July 1, 2008. It includes an increase of the tax on cigarettes by 4 cents annually (to adjust for inflation) for the following five years, to a total increased tax of $1.49 in 2013. Increasing the fee on cigarettes will help to reduce the number of adults and teens who smoke, thereby improving health and reducing health care costs. In Kansas, tobacco related deaths and illness are associated with $930 million health care costs annually.

Section 2, 3, and 4: Preventing Stockpiling of Cigarettes and Offsetting Cost to Wholesalers. These sections require all wholesale dealers, retail dealers and vending machine operators to file a report detailing all cigarettes, cigarette stamps and meter imprints on hand at 12:01 a.m. on July 1, 2008 and increases the tax imposed on such items from $.575 to $.625. The provisions of this section will

apply to each July 1st prior to subsequent increases in the cigarette tax in order to prevent stockpiling of cigarettes that have been marked with the previous tax stamp. In addition, it provides for discounted tax stamps for wholesale dealers in order to offset the cost of requiring the application of new tax stamps each year the tax is increased, and permits wholesale dealers to sell back any unused tax stamps to the state for a period of 6 months after time of purchase.

Section 5: Fee Increase on Smokeless Tobacco products. This section raises the tax on the distribution of tobacco products from a rate of 10% of the wholesale sales price to 57%.

Section 6: Preventing Stockpiling of Smokeless Tobacco. This section requires all distributors to report the tobacco products on hand as of July 1, 2008 and imposes a 47% tax on those products. This section is intended to prevent the stockpiling of tobacco products to be sold under the lower previous tax.

Section 7: Accounting for all Tobacco Products Within the State. This section every distributor with a place of business in Kansas file a return to the director of taxation on or before every 20th day of each calendar month detailing the quantity and wholesale sales price of each tobacco product brought, made, and sold in this state during the prior month.

Section 8: Creating the Health Reform Fund. This section creates the new Health Reform fund within the state treasury with the Kansas Health Policy Authority or its designee approving vouchers from the fund. The section also requires certain transfers to be made out of the State General Fund to the Health Reform Fund with $61.57 million in 2009, $68.62 million in 2010, $68.24 million in 2011, $67.8 million in 2013, and $66.95 million in 2014. With the revenue generated from the cigarette and smokeless tobacco tax going directly into the State General Fund this section requires only the amount needed for health reform is actually placed within the Health Reform fund. Therefore, if the tobacco tax takes in more than expected the State General Fund will reap the benefits and not the Health Reform Fund. (Also referenced in SB 541 Section 5)

Part IV. Smoking Ban: ***Pending KHPA Board discussion on 2-19-08***

Part V. Appropriations Requests

1. **Increase Medicaid Provider Reimbursement for Use of Medical Home.**

2. **Wellness Grant Program for Small Businesses.** Legislative request of $100,000 new appropriation.

3. **Dental Coverage for Pregnant Medicaid Beneficiaries.** Legislative request of $543,833 of SGF.

4. **Provide Tobacco Cessation Support for Medicaid Beneficiaries.** Legislative Request of $200,000 of SGF.

5. **Access to Care for Kansas Children and Young Adults.** Legislative request of $1,008,647 of SGF.

6. **Physical Fitness & School Health Programs.** Legislative request of $550,728.

7. **Improve Access to Cancer Screening.** Legislative request of $6,666,939.

2-8-08

Components of KHPA Health Reform FY 2009

Reforms that require statutory language:	Bill Number and FY 2009 Costs
P2 (1) Promoting Medical Homes: Defining a Medical Home in Statute	SB541
P2 (8) Improve Healthy Behaviors in the Schools: Include Commissioner of Education on KHPA Board	SB541
P2 (12) Improve Healthy Behaviors in the Workplace: Develop Grant Program to Facilitate Wellness Initiatives in Small Businesses	SB541 **Legislative Request: $100,000 SGF.**
P3 (2) Providing and Protecting Affordable Health Insurance: Expanding Insurance for Low-Income Kansans	SB541 Expands Kansas Healthy Choices (Premium Assistance) to childless adults up to 100% FPL in FY2012.
P3 (1) Providing and Protecting Affordable Health Insurance: Access to Care for Kansas Children and Young Adults	SB540 Creates young adult policies for 18 through 25 year olds; Increases the age of dependents on parents health insurance through age 25.
P3 (3) Providing and Protecting Affordable Health Insurance: Affordable Coverage for Small Business	SB540 Establishes very small employer group. Very small employers are defined as employers who employ at most 10 employees and includes sole proprietors. Reorganizes the Kansas Business Health Partnership Act into the Kansas Small Business Health Policy Commitee. The purpose of this committee is to establish a voluntary health insurance clearinghouse, to assist in accessing cafeteria plans, analyze the use of reinsurance and transfers the cafeteria promotion program from the Department of Commerce to KHPA.
P2 (5) Improve Healthy Behaviors in Families and Communities: Increase Tobacco User Fee	SB542; HB2737
P2 (6) Improve Healthy Behaviors in Families and Communities: Enact a Statewide Restriction on Smoking in Public Places	

Reforms requiring funding through existing KHPA budget:	
P2 (3) Promoting Medical Homes: Implement Statewide Community Health Record (CHR).	**Legislative request: $383,600 SGF in KHPA budget to expand pilot.**

Reforms that require a new appropriation but no statutory changes:	
P1 (2) Promoting Informed Use of Health Services: Improving Health Literacy.	**Legislative request: $140,000 SGF**
P2 (14) Additional Prevention Options (1): Inclusion of Dental Coverage for Pregnant Medicaid Beneficiaries.	**Legislative request: $545,833 SGF.**
P2 (15) Additional Prevention Options (2): Provide Tobacco Cessation Support for Medicaid Beneficiaries.	**Legislative request: $200,000 SGF.**
P3 (1) Providing and Protecting Affordable Health Insurance: Access to Care for Kansas Children and Young Adults.	Outreach and marketing to children already eligible for HealthWave. **Legislative request: $2,153,222 SGF.**
P2 (11) Schools: Physical Fitness and School Health Programs.	**Legislative request: $550,728 SGF.**
P2. (16) Additional Prevention Options (3): Improve Access to Cancer Screening	**Legislative request: $6,666,939 SGF.**

Reforms requiring no Legislative action:	
P1 (1) Informed Use of Health Services: Transparency for Consumers: Consumer Health Care Cost and Quality Transparency Project.	
P2(2) Promoting Medical Homes: Increase Medicaid Provider Reimbursement.	
P2 (4) Promoting Medical Homes: Promote Insurance Card Standardization.	
P2 (7) Improve Healthy Behaviors for Families and Communities: Partnering with Community Organizations.	
P2 (9) Improve Healthy Behaviors in the Schools: Collect information on Health/Fitness of Kansas School Children.	
P2 (10) Improve Healthy Behaviors in the Schools: Promote Healthy Food Choices in Schools.	
P2 (13) Improve Healthy Behaviors in the Workplace: Improve Food Choices in State Cafeterias and Vending Machines.	

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KANSAS HEALTH POLICY AUTHORITY

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Bill Guide For Health Reform Recommendations

Prepared by the Kansas Health Policy Authority
for the 2008 Legislative Session

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SB 541: KHPA Reforms

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Insurance Reforms

Section 1: Establishing Very Small Employer. This section defines and creates a group for very small employers. Very small employers are defined as employers who employ at most 10 employees and includes sole proprietors.

Section 2: Creating Young Adult Policies. This section defines and creates a separate group for young adults for the purposes of health insurance. A young 2 adult is defined as an individual who has attained the age of 18 through the age of 25 (under the age of 26). Creating a specific group in insurance law for young adults will lead to creation of more affordable insurance products with benefit packages tailored to the needs of young adults and will expand health insurance access among the 20% of young adults who are uninsured.

Sections 3, 4, & 5: Increasing Age of Dependants on Parent's Health Insurance. These sections amend current insurance law by permitting that parents can keep their children on their insurance plan until the children reach the age of 26, as long as the children are dependents. Allowing individuals who are under the age of 26 to remain on their parent's health insurance policy will reduce the 20% of young adults who are uninsured.

Sections 6, 7, 8, & 9: Creating the Kansas Small Business Health Policy Committee. These sections reorganize the Kansas Business Health Partnership Act (BHP) by (1) establishing the Kansas Small Business Health Policy Committee and (2) removing the subsidy function of the BHP (which was not operational) . The purpose of this new committee is to establish a voluntary health insurance clearinghouse for small businesses to assist with the acquiring of insurance for their employees and accessing cafeteria plans (Section 125 plans) and also analyze the use of reinsurance. The committee will report to the KHPA Board and provide annual reports to the Board and Commissioner of Insurance.

Sections 10 & 11: Transfer Cafeteria Plan Promotion Program From Commerce to KHPA. Sections 10 and 11, moves from the Department of Commerce to the Kansas Health Policy Authority the section 125 cafeteria plan promotion that was established as part of SB 11. The newly created Kansas Small Business Health Policy Committee will direct the cafeteria plan promotion with the goal of encouraging and expanding the use of cafeteria plans.

3-21

Access to Care for Kansas Children and Young Adults

FAST FACTS

Policy

For children, target and enroll the children up to 200% FPL currently eligible but not enrolled in Health-Wave 19 and 21. For young adults, change Kansas insurance law to allow parents to keep young adults (through age 25 years) on their family insurance plan and develop specific Young Adult Plans (YAPs) that provide health care insurance options with limited benefit packages and lower premiums. (Note: In the United Methodist Health Ministry Fund report, YAPs are discussed within the third initiative describing voluntary insurance market reforms.)

The policy would include specific targets and timelines for the improved enrollment for children that if not met, would trigger additional review by the KHPA Board. This trigger mechanism will initiate the KHPA Board's review of further policy options, including the consideration of mandating health insurance coverage for children in Kansas .)

Background

States that have been successful at increasing enrollment penetration for eligible but not enrolled in government-funded health care have extended their outreach programs operationally and included web based enrollment, public-program coordination/collaboration, school-based outreach programs, and out-stationing eligibility workers with culturally competent community partners. Each of these efforts entails moving the point of engagement with the child or family into the family's everyday life through a known contact, local geography or both.

Just as with the broader uninsured population, there are many reasons young adults lack health care coverage, but key differences of the young adult population can be capitalized upon. First, young adults are more likely than their uninsured older counterparts to live at home, be supported by their parents, or be enrolled in secondary education institutions. Secondly, young adults typically enter the workforce in lower paying jobs and are more likely to work in jobs where health insurance is not offered. Third, young adults are, in general, healthier than their older counterparts and may see less benefit in paying top dollar for comprehensive health insurance plans. A change in Kansas insurance law to allow parents to keep dependent young adults on their family insurance plan through age 25 would assist in providing transitional insurance to young adults as they leave home, enter the workforce, and gain employer-sponsored coverage. Development of YAPs – health insurance products specifically designed for adults aged 19-24 years old – would be a voluntary program aimed at offering a market specific insurance product with a limited benefit package and correspondingly lower premiums. These plans would be developed by the state in conjunction with private health insurers. This again would require changes to Kansas insurance law. Kansas would need to develop regulations covering areas such as who could sell the product, minimum coverage standards, and rating requirements for the product.

Population Served

15,000 additional children would enroll in Medicaid and approximately 5,000 additional children would enroll in SCHIP as a result of an extremely visible and effective outreach, web-based enrollment and facilitated enrollment processes specifically targeting uninsured lower income children eligible for public programs.

Developing Young Adult Plans (YAPs) with limited benefits targeted at young adults ages 19-24 years old would insure 15,000 additional young adults.

RELATES TO SB 540: SECTIONS 2, 3, 4, 5

3-22

Access to Care for Kansas Children and Young Adults

FAQs

Recommendation:

Change Kansas insurance law to allow parents to keep young adults, through age 25 years, on their family insurance plan and develop specific Young Adult Plans (YAPs) that provide health care insurance options with limited benefit packages and lower premiums.

Legislative Action:

Enact legislation extending the age limit for dependent coverage and establishing YAP health insurance coverage

How many young adults in Kansas lack insurance coverage?
Approximately one quarter (24 percent) of young adults 18 to 25 years of age are uninsured – the highest sub-group of the uninsured in the state. Nearly two of five college graduates and one-half of high school graduates who do not go on to college will be uninsured for a period during the first year after graduation.

What kind of policies will be implemented to deal with the problem of uninsured youth?
The KHPA is looking at two types of policies. The first policy is designed specifically with young adults in mind, focusing on health promotion, disease prevention and catastrophic coverage. This policy would be more affordable than more comprehensive health insurance that would typically be offered to families in Kansas. The second policy focuses on allowing young adults to remain on their parents' policy as long as they are dependents through the age of 25.

Why aren't young adults choosing to purchase insurance when they become uninsured?
Although many believe that young adults simply choose not to purchase health insurance to spend their money elsewhere, research indicates that 70 percent of young adults regard health insurance as a very important factor when choosing a job. Compared to 62 percent for older age groups, only 42 percent of workers aged 19-29 have access to job-based health benefits. Among 19-23 year olds, only 1/5 have insurance coverage through their employer, partly because a majority work part-time - only 1/3 work full-time during the year. Many of the rest find the cost of health insurance too expensive.

What is the KHPA doing to educate young people about the availability of health insurance and encourage them to make the purchase of health insurance a personal financial priority?
The KHPA is recommending the creation of a web-based health insurance clearinghouse to educate consumers about policies available to them, including information about tax advantaged health insurance (Section 125 plans). The clearinghouse would not operate as a regulatory entity, but as an educational tool to compare health insurance plans. In addition, Kansans should be provided with information about the cost and quality of health care services as well as the appropriate use of medical services ("evidence based medicine") which will be provided online in collaboration with the State's libraries through the Transparency for Consumers: Health Care Cost and Quality Project. All of these initiatives would be linked to the KHPA website and focus on outreach so that Kansans are aware that these tools are available.

RELATES TO SB 540: SECTIONS 2, 3, 4, 5

3-23

Affordable Coverage for Small Business

FAST FACTS

Policy

Help small employer better access health insurance by developing a voluntary health insurance clearinghouse to assist small employers to access health insurance and tax-preferred health insurance premiums through Section 125 plans. Stabilize and lower health insurance rates for the smallest and newest businesses by creating a new "micromarket" for sole proprietors and very small employers (VSG - one to ten employees) within the small group market. Establish a reinsurance program to spread the risk of this new micro-market among all carriers and the State.

On January 23, 2008 KHPA received notice that the Robert Wood Johnson Foundation had awarded them a grant of $199,858 to further develop the elements of the reformed individual and small group health insurance model. The proposed refinement project would encompass two phases:

1. Development of a detailed sole proprietor/very small employer health insurance reform implementation plan
   - Convening a stakeholder advisory panel
   - Additional health insurance data collection related to sole proprietors and micro-firms in Kansas
   - Consultation with national health insurance experts
   - Chronic disease burden mapping for Kansas with consultation on construction of chronic care management strategies
2. Modeling of the refined Updated Sequential Health Insurance plan to estimate cost and impact of the detailed plan

Legislative Action:

Amend Kansas business health partnership act K.S.A. 40-4701 through 40-4707 deleting the Business Health Partnership duties and assigning the former Business Health Policy Committee, now titled the Small Business Health Policy Committee, the voluntary health insurance clearinghouse duties. The clearinghouse functions include assisting sole proprietors and very small businesses in accessing health insurance and tax-preferred health insurance premiums.

Population Served

Overall, the new VSG market would insure 5,900 working Kansans and their families prior to the impact of the reinsurance program. The introduction of the reinsurance program and the subsequent drop in premium would result in an additional 6,000 working Kansans and their families insured.

The newly established voluntary insurance clearinghouse will be available to assist all of Kansas' small employer groups but has no direct population impact.

RELATES TO SB 540: SECTIONS 1, 6, 7, 8, 9, 10, 11

3-24

KHPA Reforms

Section 1: Adding Commissioner of Education to KHPA Board. This section adds the Commissioner of Education to the KHPA Board as a non-voting ex officio member. The KHPA Board understands the importance of promoting healthy behaviors at an early age and the addition of the Commissioner of Education will provide a source of knowledge for the implementation of any school programs.

Section 2: Medical Home Definition. This section sets out a framework for defining a medical home in Kansas for state-funded health programs in order to increase care coordination, improve health outcomes, and decrease health care costs.

Section 3: Small Business Wellness Program. This section establishes within the Kansas Health Policy Authority a small business wellness grant program. The purpose of this section is to develop a community grant program that provides technical assistance and funds to assist small businesses in establishing wellness programs for their employees.

Section 4: Expansion of Premium Assistance. This section expands on the premium assistance program passed in SB 11 – slated to begin January 2009 – to include low income adults without children. Premium Assistance, called Kansas Healthy Choices, is a new health insurance program that provides private health insurance to very low income Kansas families. After full phase in of the premium assistance for low income families up to 100% of the Federal Poverty Level (in FY 2011), childless adults under 100% of poverty (about $10,700 in 2007) will be eligible to participate (in FY 2012).

Section 5: Creating the Health Reform Fund. This section creates a "Health Reform Fund" within the State treasury. Revenues from a proposed increase in the state tobacco user fee will be deposited in the interest bearing fund and the funds will be utilized solely to pay for health reforms. (Also referenced in SB 542 Section 8)

8-25

Include Commissioner of Education on KHPA Board

FAST FACTS

Policy

Expand the KHPA Board to include an ex-officio seat for the Kansas Commissioner of Education.

Background

The KHPA Board is comprised of nine appointed voting members and seven ex-officio members representing government agencies with critical roles in the promotion and development of health care policies, administration of health care programs, and resources throughout Kansas. Inclusion of the education community in fulfilling this mission is essential to establishing a healthy future for our children. From an implementation perspective, the KHPA Board does not have the authority to implement this addition and should make known its intention to the Legislature due to the statutory origin of the KHPA.

Population Served

Kansas school children will be the greatest beneficiaries of a KHPA Board composition that recognizes the importance of health care policies that include the insight of the education community.

RELATES TO SB 541: SECTION 1

3-26

Include Commissioner of Education on KHPA Board

FAQs

Legislative Action:

Statutory change is necessary to add the Education Commissioner to the KHPA board.

Summary: The KHPA board currently consists of nine voting members and seven ex-officio government employees. The mission of the Board is to develop and maintain a coordinated health policy agenda that combines the effective purchasing and administration of health care with promotion oriented public health strategies. The KHPA Board's role is to set policy direction for the agency and to provide oversight to the budget and operation of the Medicaid, HealthWave, and State Employees Health Benefit programs. The seven ex-officio Board members serve as a resource and support for the nine voting members. In addition, the inclusion of other state agencies on the KHPA board enables a coordinated effort across the many disciplines that encompass the health of Kansans.

Why should the Kansas Commissioner of Education be included on the KHPA Board?

We develop many of our health habits as children. One of the central focus areas in these reforms is encouraging healthy behaviors in schools. Specifically, the reforms address school lunches, vending machines, and physical education. The Kansas Commissioner of Education could provide expert advice on implementing these initiatives to achieve success.

What is the state of our children's health?

Obesity has become the second greatest threat to the long-term health of children. It is projected that one of every three children born in 2000 will develop diabetes in their lifetime due to obesity.

Is it appropriate for schools to play a significant role in our children's health?

Improving our children's health requires a coordinated effort of home and school. Children spend a significant portion of their day at school and it is critical that this environment promotes good health through food offerings and physical activity.

RELATES TO SB 541: SECTION 1

3-27

Defining a Medical Home in Statute

FAST FACTS

Policy

Develop a statutory or regulatory definition of a medical home for state-funded health programs (Medicaid/HealthWave and the SEHBP).

Background

One of the components of Kansas health reform is to promote a person-centered medical home as a way to improve the quality of primary health care, promote improved health status, and ultimately help to control the rising costs of health care. The designation of the medical home is a cornerstone of support for other areas of the KHPA preventive health agenda. Defining in statute the meaning of a medical home in Kansas will provide the framework for further development and implementation of a medical home model.

Promoting the development and use of medical home practices will help to organize health care services through a medical home model with the goal of improving health outcomes and containing health care costs. States, such as Colorado, Washington, Missouri, and Louisiana, are advancing the medical home model and passing legislation to organize Medicaid programs around the medical home concept. North Carolina has used existing legislative authority to extend the medical home concept to its Medicaid and State Children's Health Insurance Program (SCHIP) populations. A number of states have defined a medical home in statute, such as Louisiana, Colorado, and Massachusetts.

The medical home in Kansas should recognize the importance of mental health services and the relationship between physical and mental health. In addition, addressing the appropriate services and continuum of care over the life span is critical to the medical home, which should include a focus on improvement on end-of-life care.

Population Served

The population served are all beneficiaries of state-funded health care plans (Medicaid/ HealthWave and the SEHBP), as well as Kansas health care providers.

RELATES TO SB 541: SECTION 2

3-28

Defining a Medical Home in Statute

FAQs

What is the definition of a medical home?
A "Medical Home" refers to a model of health care delivery that is person centered and family centered, providing accessible and continuous evidence-based, comprehensive, preventive and coordinated health care guided by a personal primary care provider who coordinates and facilitates preventive and primary care to improve health outcomes in an efficient and cost effective manner.

What specific kinds of care are offered in a medical home?
In addition to offering health care services, a medical home model of care includes features such as: (a) a focus on patient communication; (b) patient tracking with reminders for providers and patients about needed health care; (c) use of evidence based medicine and prevention; (d) coordination of care/follow up for patients who receive inpatient or outpatient health care services; (e) support for patients in the self-management of their health conditions; (f) electronic prescribing of pharmaceuticals; (g) tracking of lab tests, particularly for abnormal results or for duplicate tests; (h) tracking of referrals to other health providers; (i) surveys patients for satisfaction and goals for provider performance; (j) use of advanced electronic communications such as an interactive website, email communications, or electronic care management support.

Aren't all primary care providers already providing medical homes today?
Many primary care providers offer some features of a medical home, but there are few incentives in our health care system for providing access to the full range of medical home services. Recent research demonstrates that providing care through this model improves health outcomes in children and adults, and can help control the rising cost of health care. The Institute of Medicine has determined that the medical home is one of six aims for our health system and is the foundation of patient centered care.

How is this different from the managed care gatekeeper model of care?
"Managed care" was a model of health services delivery largely driven by health insurers and employers. Rather than managing health care, many believe that the focus of "managed care" was "managing cost." Patients and providers often felt that managed care limited access to needed health services. In contrast, the medical home model of care is not designed to limit care but rather better coordinate care among providers, through a personal primary care provider. This creates a culture of preventive care and facilitates patient health which, in turn, improves quality of life and reduces health care costs.

RELATES TO SB 541: SECTION 2

3-29

Goals of a medical home are to provide consumers with increased access to needed health services, more information about self-management of health conditions, and personalized help in navigating the complex health care system.

Why is it important to provide coordinated, personalized care?
Because our health system is so fragmented – with patients, providers, and purchasers operating under a different set of financial incentives – health care costs in Kansas and across the United States continue to rise at an unsustainable rate. Indeed, we pay double per capita any other industrialized country in the world, but with far worse health outcomes. A medical home model of health care places at the center of our health system the consumer-provider relationship, improved overall health status, and increased personal responsibility for our health.

Who is interested in advancing a medical home model of health care?
The support for a medical home has been endorsed by the Kansas Chapters of the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), the American Osteopathic Association (AOA), the American Medical Association (AMA), and the
Kansas Association of the Medically Underserved (KAMU), representing safety net clinics across our state. As part of determining the measures and standards for a medical home in Kansas, stakeholder feedback will be solicited from all of these organizations and other various health care practitioners, such as nurse practitioners and physician assistants, rural health clinics and safety net health care clinics, and organizations with specific expertise in various aspects of the continuum of care. Expanding the person-centered medical home will require partnership with mid-level practitioners and safety net clinics, which are critical to serving the needs of rural communities and underserved areas in Kansas.

How much money will it cost the State of Kansas?
This legislation directs the Kansas Health Policy Authority and the Kansas Department on Health and Environment to work with state stakeholders on developing measures and standards for a medical home in the Kansas Medicaid/HealthWave programs and State Employee Health Plan Kansas. *There is no associated fiscal note.*

RELATES TO SB 541: SECTION 2

3-30

Develop Grant Program to Facilitate Wellness Initiatives in Small Businesses

FAST FACTS

Policy

Develop a community grant program to provide technical assistance and start-up funds to small businesses to assist them in the development of workplace wellness programs.

Background

Large employers have frequently embraced workplace wellness programs as mechanisms to improve employee health, decrease absenteeism, and enhance productivity. The costs of starting such programs are prohibitive for small employers who often do not have adequate resources and economies of scale to pay for these kinds of programs. The component of "personal responsibility" within health care reform encompasses not only individual choice, but establishing an environment which facilitates the choice for health. Workplace wellness programs embody this strategy.

Well-designed worksite health interventions can have an enormous impact on disease prevention and control, resulting in significant savings in health care spending, improved presenteeism, and increased productivity. A comprehensive worksite wellness program consists of health education, supportive social and physical environments, integration of programs into the organizational structure, linkage to related programs such as employee assistance programs (EAP), and screening programs linking to health care. Comprehensive worksite health promotion programs can yield a $3 to $6 return on investment (ROI) for every dollar spent over a 2–5 year period. Worksite health promotion programs can reduce absenteeism, health care, and disability workers' compensation costs by more than 25% each.

Over 80% of businesses with over 50 employees have some form of health/wellness programs, but they are much less available in small businesses. Small businesses have limited resources and their lack of staff, budget, and wellness knowledge are barriers to providing wellness programs. Once established, however those wellness programs are quite economical costing $30-$200 per employee per year.

Population Served

The population served is employees working for small Kansas firms.

Data from the US 2000 Census detailing industry employment by size of industry documents the prevalence of small employers in Kansas. Of the 67,900 establishments with employees in Kansas, over 79% are in the under 100 employee size category. Business establishments (28,144) with one to four employees comprise 41.5% of the total, establishments (10,892) with five to nine employees comprise 16% of the total, establishments (6,969) with 10 to 19 employees comprise 10.3% of the total, and businesses (7,833) with 20 to 99 employees comprise 11.5% of the total.

RELATES TO SB 541: SECTION 3

3-31

Develop Grant Program to Facilitate Wellness Initiatives in Small Businesses

FAQs

Legislative Action:

$100,000 SGF appropriation.

Summary: Over 80% of businesses with over fifty employees offer health/wellness programs to their employees. Because small businesses may not have the same financial resources, staff, and wellness knowledge as large businesses, it is important to assist them in establishing workplace wellness programs.

What is a worksite wellness program?

A wellness program may take many forms and should be left to the individual business to determine the best program to meet employee needs. Some components might include health education, a supportive environment, and access to employee assistance and screening programs.

Is a grant program of this size significant enough to have an impact for small businesses?

This is a first step in trying to integrate health and wellness as part of a lifestyle. Applying a local approach by making funds available to small businesses may lead to a groundswell of other businesses adopting wellness programs. This is a critical sector to target because over 79% of Kansas businesses have less than 100 employees. Wellness opportunities need to be available at work, where adults spend the majority of the day. By providing funds for technical assistance and funding for start-up programs employees can engage in for healthy habits at work as well as home.

Why should a competitive grant system be used to encourage small business wellness?

Competition of ideas leads to innovative outcomes. Allowing businesses to compete for funding allows the flexibility to adopt unique programs that fit a particular business' employees and infrastructure.

Is there a cost benefit to adopting workplace wellness?

It is estimated that wellness programs only cost $30-$200 per employee per year. Compare that cost to the reduced absenteeism, increased employee productivity, and improved health care costs that result from wellness program and the conclusion is that it is a wise investment.

RELATES TO SB 541: SECTION 3

3-32

Expanding Insurance for Low-Income Kansans.

FAST FACTS

Policy

Expand population for the Premium Assistance program to include adults (without children) earning up to 100% FPL ($10,210 annually).

Background

This voluntary program is aimed at integrating the poorest childless adults into the health care system by providing them with subsidized access to private health care insurance. Adults without children do not fit within Medicaid's traditional eligibility categories, although the Centers for Medicare & Medicaid Services (CMS) have provided states with additional options within the Deficit Reduction Act (DRA). States have taken a variety of approaches to covering childless adults, typically either through state-only programs like Connecticut's State Administered General Assistance (SAGA) program or by pursuing waiver authority through the federal government and the CMS waiver process.

The structure for this initiative would be an expansion of the covered population eligible for Premium Assistance as specified in SB 11. The newly eligible individuals could be served within the same administrative structure that is being developed for the current SB 11 Premium Assistance program.

Kansas Healthy Choices:

- **Saves money.** The purchase of private insurance through Kansas Healthy Choices helps control state health care spending for the poverty level population by providing broader access to preventive care, and strengthens and expands private markets, rather than replacing or eliminating them.
- **Prudently partners with other funding resources.** This program ensures state access to 60% Federal matching funds. In addition, this wrap-around assistance strategically relies on employer contributions when available.
- **Unites families in health care.** Kansas Healthy Choices provides coverage for each member of the family under one plan, strengthening a family culture of prevention, health literacy, and care.
- **Breaks a vicious cycle.** Those without insurance use fewer preventive and screening services, are sicker when diagnosed, receive fewer therapeutic services and have poorer health outcomes in terms of mortality and disability rates. In addition, this group has lower earnings due to poor health.
- **Makes an impact.** Over the next three years, Kansas HealthChoices is expected to provide about 20,000 existing and 24,500 newly eligible caretaker adults and their children with the choice of private insurance options and a "medical home" model of health care services.

Population Served

The population served are adults (without children) earning up to 100% FPL ($10,210 annually). 39,000 low income Kansans would become insured.

RELATES TO SB 541: SECTION 4

Expanding Insurance for Low-Income Kansans.

FAQs

Recommendation:

Kansas Healthy Choices is an effective, prudent use of public funds to save public dollars in the long-term, strengthen private insurance markets, and improve the quality of life and access to health care for thousands of Kansas families. Supporting Kansas Healthy Choices means providing a smart path to private insurance for those who would otherwise be unable to attain coverage by themselves.

Legislative Action:

Statutory change to expand premium assistance eligibility.

Premium Assistance. Kansas Healthy Choices—previously known as premium assistance—was authorized by the Legislature and Governor in May 2007 with the signing of Senate Bill 11. It targets health insurance assistance to low-income families.

Premium Assistance Expansion. The 21. reform recommendations currently being proposed include *expanding* premium assistance to include health insurance assistance to low income adults without children.

Summary: Premium assistance is the use of public, employer, and potentially individual contributions to purchase private health insurance for Kansas families living in poverty who cannot otherwise afford coverage.

Since passage of SB 11 in May 2007, KHPA has engaged in an extended, open, and participatory process to complete the program design and implementation of the premium assistance program Kansas Healthy Choices. The program will be implemented in January 2009.

How do families enroll and select a health plan under Kansas Healthy Choices (KHC)?

When a family is determined to be eligible for KHC, and has access to an employer-sponsored insurance plan, the benefits and cost effectiveness of the plan are reviewed. If it is determined that the employer-sponsored plan is cost effective, the family will be reimbursed for the employee portion of the premium. However, if the employer-sponsored plan is not cost effective, the family will be eligible to enroll in the KHC procured plan. KHC families eligible for the procured plan will receive a packet of information along with instructions on how to select one of the statewide health plans, a plan for themselves and their eligible family members. If a beneficiary does not choose a plan, the family is systematically assigned to the most appropriate plan. KHC participants will not be subject to waiting periods or pre-existing condition clauses.

How does premium assistance save the State of Kansas money?

Premium assistance provides insurance to low-income families, targeting those who tend to cost the most to public assistance programs. Those without insurance use fewer preventive and screening services, are sicker when diagnosed, receive fewer therapeutic services and have poorer health outcomes in terms of mortality and disability rates.

In addition, this group has lower earnings due to poor health. It is important to note federal regulations state that insurance provided through a premium assistance program cannot be more expensive than the cost of providing services for eligible members than through Medicaid or SCHIP.

RELATES TO SB 541: SECTION 4

3-34

Tobacco Fee Assessment

Section 1: Fee Increase on Cigarettes. This section increases the tax on a package of cigarette by $.50 to $1.29, beginning on July 1, 2008. It includes an increase of the tax on cigarettes by 4 cents annually (to adjust for inflation) for the following five years, to a total increased tax of $1.49 in 2013. Increasing the fee on cigarettes will help to reduce the number of adults and teens who smoke, thereby improving health and reducing health care costs. In Kansas, tobacco related deaths and illness are associated with $930 million health care costs annually.

Section 2, 3, and 4: Preventing Stockpiling of Cigarettes and Offsetting Cost to Wholesalers. These sections require all wholesale dealers, retail dealers and vending machine operators to file a report detailing all cigarettes, cigarette stamps and meter imprints on hand at 12:01 a.m. on July 1, 2008 and increases the tax imposed on such items from $.575 to $.625. The provisions of this section will 3 apply to each July 1st prior to subsequent increases in the cigarette tax in order to prevent stockpiling of cigarettes that have been marked with the previous tax stamp. In addition, it provides for discounted tax stamps for wholesale dealers in order to offset the cost of requiring the application of new tax stamps each year the tax is increased, and permits wholesale dealers to sell back any unused tax stamps to the state for a period of 6 months after time of purchase.

Section 5: Fee Increase on Smokeless Tobacco products. This section raises the tax on the distribution of tobacco products from a rate of 10% of the wholesale sales price to 57%.

Section 6: Preventing Stockpiling of Smokeless Tobacco. This section requires all distributors to report the tobacco products on hand as of July 1, 2008 and imposes a 47% tax on those products. This section is intended to prevent the stockpiling of tobacco products to be sold under the lower previous tax.

Section 7: Accounting for all Tobacco Products Within the State. This section every distributor with a place of business in Kansas file a return to the director of taxation on or before every 20th day of each calendar month detailing the quantity and wholesale sales price of each tobacco product brought, made, and sold in this state during the prior month.

Section 8: Creating the Health Reform Fund. This section creates the new Health Reform fund within the state treasury with the Kansas Health Policy Authority or its designee approving vouchers from the fund. The section also requires certain transfers to be made out of the State General Fund to the Health Reform Fund with $61.57 million in 2009, $68.62 million in 2010, $68.24 million in 2011, $67.8 million in 2013, and $66.95 million in 2014. With the revenue generated from the cigarette and smokeless tobacco tax going directly into the State General Fund this section requires only the amount needed for health reform is actually placed within the Health Reform fund. Therefore, if the tobacco tax takes in more than expected the State General Fund will reap the benefits and not the Health Reform Fund. (Also referenced in SB 541 Section 5)

3-35

Increase Tobacco User Fee

FAST FACTS

Policy

Institute an increase in the tobacco user fee. It is proposed that the current excise tax on cigarettes be raised $.50 per pack and an increase in the tax rate of other tobacco products (chewing tobacco, snuff, dip, cigars, etc.) to 57% of the wholesale price.

Background

The burden of tobacco use in Kansas is great. Each year tobacco causes over 4,000 Kansas deaths, and generates nearly $930 million in health care costs ($196 million within the Medicaid program alone). Policy research has shown that raising the cost of tobacco products is an effective means to decrease the rates of tobacco use. A 10% increase in the price of a pack of cigarettes is associated with a 4% drop in tobacco use (in real terms, an increase of $.50 per pack of cigarettes may result in 20,000 of the current 400,000 adult smokers in Kansas quitting). The effect is even more pronounced among price-sensitive teens, where a similar price rise results in a 7% reduction in smoking rates.

Fifty percent of tobacco smokers begin their tobacco use before the age of 14. Not only do the habits of adults begin in childhood, but tobacco also serves as a gateway to other substance use among youth. Children and adolescents consume more than one billion packs of cigarettes a year. An increase in the excise tax on tobacco products has been one of the most effective ways to discourage youth from starting to smoke. Such a policy not only serves as an effective deterrent to tobacco use, but as an acknowledgement of the health costs that all Kansans incur as a result of usage.

Population Served

The entire Kansas population, including the 20% who currently smoke, would benefit in a reduction of the $930 million health care cost associated with tobacco consumption. The 21% of high school students and 6% of middle school students who currently smoke would benefit from having a substantial barrier to smoking. The 9.3% of adult males and the nearly 20% of high school males who currently use some type of other tobacco products would benefit from a substantial barrier to using other tobacco products.

RELATES TO SB 542 (HB 2737)

3-36

Increase Tobacco User Fee

FAST FACTS

Tobacco use is the leading cause of preventable deaths and health care costs. Increasing levels of imposed tobacco user fees have been demonstrated to decrease smoking rates, resulting in long-term savings in lives and costs. At the end of 2005, the average state excise tax on cigarettes was $.922 per pack and by early 2007 that figure had risen to about $1.03 per pack. Currently the excise tax on a pack of cigarettes in Kansas is $.79 per pack. Tobacco use costs Kansans the equivalent of $.86 per pack of cigarettes sold to pay for the tobacco-related illness of Medicaid recipients alone. However, Kansas currently collects only $.79 per pack of cigarettes in health impact fees to offset this expenditure (KDHE). An increased excise tax on all tobacco products would both reduce the number of youth who take up smoking and diminish the annual $930 million health care costs associated with tobacco consumption.

Similarly, increasing the state tax on non-cigarette tobacco products will raise new state revenues and help to reduce tobacco use levels, especially among youth, thereby reducing related harms and costs as well. Put simply, the increased revenue per package of each tobacco product sold brings in far more new revenue than are lost by the reduction in tobacco product consumption and sales prompted by the tax increase.

Over 9% of adult males in Kansas currently use chewing tobacco or snuff. In rural areas, prevalence is known to exceed 17%. Among high school males, nearly 1 in 10 reports using chewing tobacco, snuff or dip and 2 in 10 report smoking cigars. These other tobacco products are currently taxed at a rate of 10% of wholesale price. To avoid making less-expensive other tobacco products gateway to cigarette addiction or an alternative to quitting or cutting back for smokers, it is important that state tax rates on other tobacco products parallel the state's tax rate on cigarettes.

RELATES TO SB 542 (HB 2737)

3-37

Increase Tobacco User Fee

FAQs

Recommendation:

Increase the tobacco user fee by $.50 per pack for a total of $1.29 and the smokeless tobacco excise tax by 47 percent. Both increases will adjust annually according to inflation.

Legislative Action:

Change statute to increase fees and designate Health Reform fund for proceeds.

Summary: Increasing tobacco user fees results in three benefits for the state of Kansas. The first and most important is a reduction in smoking and better health outcomes. Second is a corresponding reduction in smoking-related health care costs paid for by all Kansans. Third is a revenue stream that will allow us to pay for health reform. Kansas currently ranks 33rd among states in amount of the tobacco user fee at $.79. In comparison to our neighboring states, only two have lower tobacco fees than Kansas. More important than these rankings are the statistics related to usage and death due to smoking. Twenty-one percent or 34,000 Kansas high school students smoke daily. Over 17% of high school males use smokeless tobacco. 17.8% or 356,000 adult Kansans smoke. The outcome of these usage statistics is that 3,900 Kansans die annually from the results of smoking. It is estimated that 54,000 Kansas children who smoke will die prematurely. In addition to the human toll is a financial one that is borne by Kansas taxpayers. Annual health care costs in Kansas that are directly caused by smoking total $927 million. The Medicaid portion of this amount is $196 million. These expenditures cost Kansas taxpayers $582 per household annually. The revenue generated will be over $61 million in the first year and will increase to $71 million by the fifth year. This amount is sufficient to pay for the health reform recommendations.

RELATES TO SB 542 (HB 2737)

3-38

How does an increase in the tobacco user fee act as a deterrent to use?

Data indicates that for every 10% increase in the fee, there is a corresponding 7% reduction in youth smoking and a reduction in overall smoking of 4%. The reason for a higher reduction with kids is because they tend to be lighter smokers and the increased price makes the product less desirable. There is also a reduction in use among pregnant women and low-income smokers as a result of fee increases. This linkage between price and consumption is supported by a 2000 Surgeon General's report. In filings with the Securities and Exchange Commission, tobacco companies point out the link between increased cost and reduced use. Wall Street tobacco industry analysts also point to this correlation.

How will the fee increase produce sufficient revenue if usage is declining?

In every state that has enacted an increase, the fee has proved to be an extremely stable source of revenue. In many cases, it is less volatile than even income tax projections, which change with economic cycles. One of the reasons for the stability of the revenue stream is that the increased price per pack offsets the reduction in total purchases. National statistics indicate an annual 2% decline in tobacco fee revenue. The KHPA proposal includes an annual $.04 price increase for five years to ensure revenue stability and the effectiveness of price as a deterrent. We will review revenues generated from the tax annually.

Why is tobacco the only product targeted for an increase?

Smoking is the number one preventable cause of death. In fact, smoking causes more deaths than alcohol, illegal drugs, murder, suicide, accidents and AIDS combined. The KHPA recognizes the impact of obesity on health outcomes and addresses that issue in several reform recommendations. While the KHPA does not oppose a tax on food with little nutritional value, there are numerous causes of obesity in addition to poor food choices. The link between smoking and lung disease shows a direct, causal relationship.

What does the term "tobacco user fee" refer to?

This is a fee that will only be paid by users of tobacco, which is approximately 20% of Kansans. These revenues will go into a designated health reform fund to pay for the costs of health reform. It is not unusual for users of products or services to bear the costs of usage. This is not unlike the toll that drivers on the turnpike pay daily to maintain transportation infrastructure. There is a considerable health care cost to all Kansans as a result of smoking. Tobacco users would pay for more of these costs through an increased fee since they utilize more health care services. A Sunflower Foundation poll shows that 64% of Kansans support raising the tobacco user fee.

RELATES TO SB 542 (HB 2737)

Enact a Statewide Restriction on Smoking in Public

FAST FACTS

Policy

Enact a statewide smoking restriction in public places, coupled with a Governor's Executive Order requiring state agencies to hold meetings in smoke-free facilities will allow Kansans to work and gather without exposure to the negative consequences of secondhand smoke on their health.

Background

This policy option recommends that legislation be enacted that prohibits smoking in all public places. Based on the health impact on cities that have enacted strict clean indoor air laws, a statewide law in Kansas could result in 2,160 fewer heart attacks and $21 million less in associated hospital charges for heart attacks alone. A recent poll indicated that 73% of Kansas adults favor such a state law or local ordinance.

Secondhand smoke is ingested in two ways: 1) through the lit end of the cigarette; and 2) by the exhaled smoke of the smoker. Cigarette smoke contains over 4,000 chemicals and is a known carcinogen. At its most severe impact, secondhand smoke results in 3,000 annual cancer deaths in the US and 35,000 deaths from heart disease. This statistic represents a stark consequence of secondhand smoke, but fails to show the full impact. Exposure to cigarette smoke also results in an increase of asthma attacks, lower respiratory tract infections in children under 18 months old, coughing, and reduced lung function. Pregnant women are particularly susceptible to having low birth weight babies as a result of secondhand smoke exposure. A 2006 Surgeon General's report notes that, "the scientific evidence indicates there is no risk-free level of exposure to secondhand smoke." The National Institute for Occupational Safety and Health (NIOSH) recommends that secondhand smoke be considered as a potential occupational carcinogen.

Enactment of smoke free policies at the state level would address the issue of business owners who believe that local control of smoking bans results in an uneven playing field as businesses compete with other jurisdictions that may have no ban in place. In Kansas, 72% of the working population is protected by worksite nonsmoking policies. (CDC Sustaining State Programs for Tobacco Control Data Highlights, 2006). More than 40 states have imposed restrictions on smoking in public places. (National Conference of State Legislatures 2004).

Smoking is the number one preventable cause of death in Kansas and 83% of Kansas adults believe it is a serious health hazard. (Sunflower Foundation 2007). Evidence has shown that statewide smoking bans decrease the smoking rate among active smokers by 10%, a potential decrease of 40,000 smokers in Kansas (KDHE).

Population Served

In Kansas, 1.4 million working adults would benefit from working and living in a smoke-free environment.

3-40

Enact a Statewide Restriction on Smoking in Public

FAQs

Recommendation:

Enact a statewide smoking restriction in public places so that Kansans can gather and work without exposure to secondhand smoke and the health consequences that result.

Legislative Action:

Adopt a statewide smoking restriction in public places.

Summary: Twenty-six states have adopted smoke-free ordinances in response to the harmful effects of secondhand smoke. In a Kansas Adult Tobacco Survey conducted in 2002-2003, 94% of those polled believe that secondhand smoke is harmful to health. This belief is supported by the data. A 2006 Surgeon General's Report states "scientific evidence is indisputable that secondhand smoke causes premature death and serious disease in both children and adults who do not smoke." The Report goes on to state that secondhand smoke is a proven cause of heart disease and lung cancer in nonsmoking adults, as well as a cause of SIDS, low-birth weight, acute respiratory infections, ear infections, and asthma attacks in infants and children. The Surgeon General noted that there is no safe level of exposure to secondhand smoke. In Kansas, 17 communities have adopted clean indoor air ordinances and several others are considering them.

Should state government set this policy?
KHPA supports local ordinances that have been adopted in the absence of a statewide standard. However, a uniform policy would ensure protection from secondhand smoke for all Kansans. A statewide policy would address the concern of business owners who believe that local control of smoke free policies results in an uneven playing field as businesses compete with other jurisdictions that may not have a smoke free policy in place. State government often takes the lead in pre-empting local control when public health is at stake.

Will a statewide smoke free law have an economic impact on hospitality businesses?
The data from other states and localities does not indicate a negative financial impact. The Surgeon General's 2006 Report examined several studies and concluded "smoke-free policies and regulations do not have an adverse economic impact on the hospitality industry." In a 2006 Zagat Survey of America's top restaurants, 58% of respondents stated they would dine out at the same frequency if restaurants were smoke free and 39% indicated they would dine out more frequently if smoke-free. Only 3% claimed they would dine out less often. Again, a statewide, uniform standard helps businesses attract clientele.

Are smoke free policies an infringement on individual rights?
An absence of a smoke free policy is an infringement on the rights of 80% of the population that does not smoke. The data confirms that there are health consequences to secondhand smoke exposure. Workers and the general public should be allowed to work and gather in places without taking on the risk of secondhand smoke. Seventy-six percent of white collar workers already have protection from secondhand smoke, but only 52% of blue collar workers have the same opportunity.

Implement Statewide Community Health Record (CHR)

FAST FACTS

Policy

Design a statewide CHR to promote the coordination and exchange of health information for state funded health programs (Medicaid/ HealthWave and the SEHBP).

Background

Improving the coordination of health care is a key component of a medical home model and the utilization of health information technology is a primary means to improve coordination. The clinical care of state-funded health plan beneficiaries is fragmented between different providers, clinics, and other health care facilities. This fragmentation leads to discontinuities in care related to lack of effective information exchange and significant inefficiency in the health care system. Similar difficulties exist in the transmission of health plan eligibility and benefit information.

Promoting a statewide exchange of clinical and financial health care information can improve efficiency; enhance the process of health care delivery, and promote patient safety. Moreover, as one of the largest payers of health care services in the state, we would leverage our considerable purchasing power to promote the use of health information technology and exchange through a statewide CHR.Improving access to personal health information by consumers will also help to promote self-management of care and personal responsibility. A statewide CHR in Kansas should integrate consumer access to allow consumers to review their personal health information (PHI) to further promote personal responsibility and self-management of care. As such, ensuring consumer privacy and security must be a key consideration in the development of health information exchange, and consumers must be given ultimate authority in who is allowed to view their health information.

Nearly two years ago, the state of Kansas implemented a pilot project to use a CHR to help deliver timely and accurate health information for Medicaid beneficiaries. The current CHR pilot project is built on administrative claims data (from health plans) and provides clinicians electronic access to claimed medical visits, procedures, diagnoses, medications, demographics, allergies and sensitivities, immunizations, vital signs, and lead screening and health maintenance data (includes Early and Periodic Screening, Diagnosis and Treatment [EPSDT] status). The record also contains an e-Prescribing component that enhances the clinician's workflow, reduces the risk of medication error caused by inadequate or unavailable patient information, and increases safety and health outcomes associated with prescription generation.

Population Served

The population served are all beneficiaries of state-funded health care plans (Medicaid/ HealthWave and the SEHBP), as well as Kansas health care providers.

Implement Statewide Community Health Record (CHR)

FAQs

Recommendation:

Implement statewide Community Health Record

Legislative Action:

$383,600 SGF is requested in the KHPA budget.

What kind of information is contained in the record?
Community Health Records allow clinicians access to a patient's medical history aggregated across multiple provider sites including claimed medical visits, procedures, diagnoses, medications, demographics, allergies and sensitivities, immunizations, and lead screening and health maintenance data, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) evaluators. In addition, the record also contains an e-Prescribing component.

What are the benefits of the CHR and e-prescribing component?
By allowing clinicians to access this information, cost savings can be realized by avoiding duplicative tests and procedures, lowering emergency department expenditures and reducing inpatient admission and outpatient visits due to incomplete data. With regard to providers, efficiencies due to the reduced time on the phone getting lab results and with pharmacies clarifying prescriptions or obtaining prior authorization are realized. The end result is increased efficiency due to time savings. Lastly, a current immunization schedule and a child's immunization record aid in the prevention of disease and the costs associated with those preventable diseases.

The e-Prescribing component incorporates drug information so that if there is a contraindication to the prescribed therapy, the clinician is alerted at the time of prescribing, rather than after the prescription is received in the pharmacy, allowing for adverse drug event savings and avoiding medication waste. This also reduces the time spent by both physicians' offices and pharmacies clarifying prescription orders and handling problems related to the prescribed drug. The CHR also incorporates the preferred drug list, generic alternatives, and general cost information, so the prescriber is aware at the time of prescribing if the drug has a generic alternative, is on the preferred drug list, and if it is a high or low cost drug. Ultimately, the e-Prescribing component reduces the risk of medication error caused by inadequate or unavailable patient information and increases safety and health outcomes associated with prescription generation.

Is a Community Health Record the same as an Electronic Medical Record?
No, the Community Health Record is a claims-driven, web-based application that allows clinicians to easily access a patient's information. The Health Record allows access to very basic information such as procedures, diagnoses, allergies and sensitivities, and immunizations. An Electronic Medical Record is software based and is composed of the clinical data repository, clinical decision support, controlled medical vocabulary, order entry, computerized provider order entry, pharmacy, and clinical documentation applications. The data is much more detailed and not as easily accessed as the Community Health Record.

Improving Health Literacy

FAST FACTS

Policy

Establish a pilot program to provide payment incentives to Medicaid/ HealthWave providers who adopt health literacy enhancement initiatives in their practice settings.

Background

An informed purchase of health care services requires health literacy by the consumer. Health literacy is the skill set required for an individual to gain access to and understand and use information in ways which promote and maintain good health. The health care system needs to improve consumers' access to health information and their capacity to use it effectively.

Nearly half of all adults have a health literacy problem. Consumers with limited literacy skills have less knowledge about, and poorer adherence to, medication and self-care regimens for certain chronic conditions; have less knowledge and less likelihood of getting specific preventive tests and exams; have poorer self-reported health and poorer health outcomes; and have increased hospitalizations and costs.

A large gap exists between the health literacy level of people and much of the health information produced by the health care industry; creating a situation where many consumers cannot understand the health information they receive from providers. In 1998, inadequate health literacy cost the US health system an estimated $30-$73 billion. A small number of states have specific projects focused on health literacy, but these initiatives are in their infancy and much more needs to be done if consumers are to achieve optimal health, particularly if they are living with chronic disease.

As part of a 2002 Council of State Governments (CSG) comprehensive study of health literacy, researchers identified "best practice" models, including the development of adult and school-age health literacy toolkits. The Kansas Consumer Health Care Cost and Quality Transparency Project will include a curriculum and toolkits for both adults and children to improve health literacy designed by the University of Kansas Medical Center and state librarians.

Population Served

The population served is Medicaid/HealthWave enrollees who are under the care of providers adopting the health literacy enhancement strategies.

KANSAS-SPECIFIC DATA

A 2007 survey by Health Literacy Innovations of Medicaid agencies indicated that Kansas was among 56% of states who had set readability guidelines for their Medicaid materials at a 6th grade reading level.

3-44

Improving Health Literacy

FAQs

Recommendation:

Establish a pilot project that provides payment incentives to Medicaid and HealthWave providers who adopt health literacy enhancements in their practice settings.

Legislative Action:

$140,000 SGF appropriation

Summary: Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. According to the American Medical Association, poor health literacy is a stronger predictor of a person's health than age, income, employment status, education level, and race. By improving health literacy, individuals become knowledgeable consumers and not merely patients navigating a complex process during a period of illness.

Is health literacy a widespread problem for consumers?
Yes, The Institute of Medicine reports that 90 million people in the United States, nearly half of the population, have difficulty understanding and using health information. As a result, patients often take medication on erratic schedules, miss follow-up appointments, and do not understand instructions such as "take this medicine on an empty stomach."

What types of items fall under the umbrella of health literacy?
It encompasses a broad spectrum of issues related to health, health care systems, and cost/access topics. Health topics include recommended preventive care and chronic-disease management, as well as the elements comprising a complete health history. Health care systems issues include the identification of providers, health care services, and settings, as well as an ability to navigate through those complex systems, completing the requisite forms and other processes. Cost and access issues related to health literacy involve a comprehension of health insurance benefit design, including coverage levels and cost sharing provisions (copayments, deductibles, and coinsurance).

Are there other benefits to health literacy in addition to informed consumers and better health outcomes?
There should be a significant cost savings for consumers if they have access to information that allows them to make good health choices by providing them with tools to evaluate the quality and value of the health services. For every other purchase that consumers make, there is an expectation that information on quality and value will be available so that consumers can comparison shop and make the best choice for their needs. A lack of information translates to a lack of competition. The data indicates that in 1998, inadequate health literacy cost the U.S. health system an estimated $30-$73 billion.

How will financial incentives to providers that practice health literacy aid consumers?
Doctors want to share information with their patients but often lack the tools or the time. Financial incentives to providers to devote time to assist consumers in better understanding treatment regimens and health promotion recommendations as well as assisting them to navigate the health care system is a first step in creating a consumer mindset in the practice setting.

Inclusion of Dental Coverage for Pregnant Medicaid Beneficiaries

FAST FACTS

Policy

Include coverage of dental health services for pregnant women in the Kansas Medicaid program.

Background

Recent studies continue to show that poor oral health has an effect on overall systemic health. One of the most convincing links is between oral infections and poor birth outcomes, specifically low birth weight babies. Providing dental benefits for pregnant women may help reduce this problem.

Kansas Medicaid pays for roughly 40% of births in Kansas. Efforts have been made with Head Start, Women, Infants, and Children (WIC), and in local health programs to educate women on the importance of good oral health during pregnancy, but without dental coverage, pregnant women are without resources to pay for oral health care. Recent evidence based studies have shown a relationship between periodontal disease and premature births and cardiac disease. Avoidance of even one premature birth can save the state from future years of medical services and disability payments.

Currently, Kansas Medicaid coverage only provides emergency dental coverage (mainly tooth extractions) for most adults on Medicaid, including pregnant women. Providing a complete dental benefit for pregnant women on Medicaid in Kansas will allow them to receive routine cleanings, fillings, and periodontal (gum disease) treatment. This type of treatment will prevent oral health emergencies and oral infections during pregnancy in many women.

Kansas pays the costs of several "million dollar" premature babies a year. The March of Dimes reports that an average premature birth costs as much as $500,000 over the lifetime of a child. The costs savings of preventing just a few of these births would easily cover the cost of the benefit. Providing additional Medicaid dental funding would support the community health clinics or "dental hubs" as they would receive compensation for treating these previously uninsured patients. The Kansas Legislature has appropriated $2 million in new money for the state's primary care safety net clinics in FY2008. It includes 500,000 earmarked for developing access to oral health care through "dental hubs."

Enrollment of dentists in the Kansas Medicaid has improved since the state changed from a capitated managed care plan to fee-for-service. However, when discussing increasing dental benefits for Medicaid beneficiaries, there is concern about the lack of capacity of dental Medicaid providers and low dental reimbursement rates. Oral Health Kansas and the Kansas Dental Association are also preparing cost estimates to increase dental reimbursement rates to help provider enrollment.

Population Served

The population served is pregnant women enrolled in Medicaid.

Inclusion of Dental Coverage for Pregnant Medicaid Beneficiaries

FAQs

Recommendation:

Include dental coverage for pregnant Medicaid beneficiaries.

Legislative Action:

$524,000 SGF appropriation

Summary: Kansas Medicaid currently covers only emergency dental care (mainly tooth extractions) for most adults on Medicaid, including pregnant women. There are 6,600 pregnant women enrolled in Medicaid.

Why do pregnant women need dental coverage?
Pregnant women are much more prone to experience problems with teeth and gums. Approximately half of women experience pregnancy gingivitis, which can lead to more serious periodontal disease. Periodontal disease can result in poor birth outcomes.

What are the potential birth outcomes?
There is a link between periodontal disease and premature babies. Premature birth is the leading cause of neonatal death (within the first month of life) and can lead to lifelong health problems such as mental retardation, blindness, chronic lung disease, and cerebral palsy. There may also be delays in physical and psychological growth. Children may also have infectious disease transmitted from the mother.

How will providing dental services to pregnant women save money?
The March of Dimes estimates that the cost of services for the lifetime of a premature child is $500,000. The cost to the Kansas Medicaid program to provide dental care would be $500,000 annually. The cost savings of preventing even one of these births would cover the cost of the benefit.

Hasn't the Legislature already provided dental coverage funding?
The legislature recognized the importance of oral health care by earmarking $500,000 for dental hubs within community health clinics in FY2008. Adding a Medicaid reimbursement may encourage more dentists to participate in these hubs.

Provide Tobacco Cessation Support for Medicaid Beneficiaries

FAST FACTS

Policy

Improve access to tobacco cessation programs (medications and counseling) in the Kansas Medicaid program in order to reduce tobacco use, improve health outcomes, and decrease health care costs.

Background

In Kansas, smoking-attributed costs for Medicaid reached $196 million in 2004 (Figure 7) (CDC Sustaining State Programs for Tobacco Control Data Highlights, 2006) and 49% of Kansas adult smokers attempted to quit and failed in 2004 compared to 55% nationwide. Kansas Medicaid currently covers the medication, Chantix, for up to 24 weeks in a year, but does not cover cessation products, such as inhalers and nasal sprays. Kansas Medicaid also does not cover group, individual, or telephone counseling.

According to the 2004 National Health Interview Survey, approximately 29% of adult Medicaid beneficiaries were current smokers. This figure was higher than the 2005 estimated rate of 20.6% for current smoking among the general population. The smoking rate for adults in Kansas is approximately 17.8%, and national data suggests the rate for Kansas Medicaid beneficiaries is higher than that of the general state population. (http://www.statehealthfacts.org).

In order to decrease smoking rates, the 2000 Public Health Service Clinical Practice Guidelines recommended tobacco-dependence treatment, which included medication and counseling. One of the 2010 national health objectives is to increase insurance coverage of evidence-based treatments for tobacco dependence among all 51 Medicaid programs. Kansas Medicaid currently provides reimbursement for some pharmaceuticals products to treat smoking cessation; however, the state does not reimburse for smoking cessation counseling. This proposal would expand reimbursement for smoking cessation treatment to include counseling in an individual and/or group setting. The expansion would be consistent with the changes occurring within the SEHBP which will include coverage of pharmaceuticals, as well as specific smoking cessation programs.

Population Served

The approximate 83,200 Kansas Medicaid beneficiaries who smoke would benefit from the increased coverage of tobacco cessation, improving health and lowering health care costs. The Kansas population overall would benefit from a less prevalent smoking environment.

Provide Tobacco Cessation Support for Medicaid Beneficiaries

FAQs

Recommendation:

Offer tobacco cessation counseling within the Medicaid program to reduce tobacco use, improve health, and decrease health care costs.

Legislative Action:

$200,000 SGF appropriation.

Summary: The Kansas Medicaid program currently covers pharmacotherapy for tobacco cessation but does not cover cessation counseling. The 2000 Public Health Service Clinical Practice Guidelines recommends offering both cessation methods to improve quit rates. One of the 2010 national health objectives is to increase insurance coverage of evidence-based treatments for tobacco dependence among all state Medicaid programs.

Why is it necessary to provide this service to the Medicaid population?

This population is disproportionately more likely to smoke than the general population. According to the *Journal of the American Medical Association*, smoking prevalence among Medicaid recipients is 39% higher than the general population. In Kansas, approximately 29% of Medicaid recipients smoke compared to less than 18% of the general population. Nearly 40% of Kansas Quitline callers report an annual income under $15,000.

Why Should Kansans pay for this type of service?

The reality is that Kansans are already paying substantially for health care costs associated with smoking. In the Medicaid program alone, Kansas taxpayers pay $196 million annually in health care costs related to smoking by Medicaid recipients. Investing $200,000 annually to help people quit smoking should reduce some of these costs and lead to healthier outcomes. According to the *Journal of the American Medical Association (*JAMA), in a study that assessed the impact and cost-effectiveness of preventive services, smoking cessation treatment was among the top ranked clinical preventive treatments, along with childhood immunizations and aspirin for adults at risk of cardiovascular disease, as the treatments that could save the most in health care costs.

What are the health benefits to Kansans who quit smoking?

According to the American Cancer Society, as soon as one year after quitting smoking, the nonsmoker will reduce the excess risk of having a heart attack and dying from heart disease in half. From 5 to 15 years after quitting, the risk of having a stroke is reduced to that of a nonsmoker. Smokers who quit before 50 may enjoy a longer life span because their risk of dying within the next 15 years is cut in half.

Why is counseling necessary if pharmacotherapy is already available? All of the tobacco policies included in the reform package target young smokers as the group most likely to quit smoking if these policies are adopted. Data indicates that young smokers are unlikely to utilize cessation medication as a stand alone option. At the same time, young people are more likely to have attempted quitting than adults in the previous year. These attempts are less successful than adults. In the young adult group, those who combined medication with counseling had the highest quit success rates.

Access to Care for Kansas Children and Young Adults

FAQs

Recommendation:

Target and enroll the children up to 200% FPL currently eligible but not enrolled in HealthWave (Medicaid/SCHIP)

Legislative Action:

$1,302,716 SGF appropriation.

What services are covered by HealthWave?
Office visits, regular checkups, immunizations, hospital services, inpatient and outpatient hospital, lab and x-ray, prescription drugs, eye doctor exams and glasses, hearing services and speech, and physical and occupational therapy. In addition dental services such as checkups, cleanings, sealants, x-rays and fillings are provided. Mental Health services such as inpatient and outpatient mental, behavioral and substance abuse services are also provided.

Is the outreach and enrollment effort an expansion of Medicaid?
No, it is not an expansion of Medicaid. The outreach and enrollment expansion effort targets those already eligible for HealthWave but not currently enrolled.

How many additional children would be enrolled?
It is estimated that approximately 15,000 additional children would be enrolled in Medicaid and approximately 5,000 additional children would be enrolled in SCHIP as a result of the effort.

How will the KHPA achieve this?
The KHPA plans to aggressively market the program through a visible and effective outreach, web-based enrollment and facilitated enrollment process specifically targeting the uninsured children eligible for public programs. Web-based enrollment will allow those children who are identified as eligible to be enrolled on the spot without delay.

Physical Fitness and School Health Programs

FAST FACTS

Policy

Strengthen physical education (PE) requirements and expand Coordinated School Health (CSH) programs.

Background

The Governor's Council on Fitness has developed a set of recommendations that calls for minimum physical activity and PE requirements that are consistent with the Kansas Wellness Policy Builder developed by the Kansas CSH program. Collaboration is underway between KDHE and the Kansas Department of Education to implement an evidence-based CSH model that provides schools with a framework to address the health and wellness needs of their students and staff.

Some of the recommendations include a minimum of 100-150 minutes of PE per week at the elementary and middle school levels, maintaining the current one unit requirement for high school graduation, and 20 minutes of recess for elementary students daily. Current law mandates PE at the elementary level, but only requires one credit unit total from middle through high school. In addition to requirements of students, the recommendations also emphasize the importance of PE teachers who are specifically trained in the PE field.

Schools are often concerned about taking away instructional time for PE classes, especially in the context of the importance of standardized testing results. However, research is emerging that indicates that improved health and physical activity status of children translates into improvement in standardized test scores. Currently, 11 states mandate physical activity for elementary schools, seven do so for middle/junior high schools, and 10 do so for high schools. Among states that mandate physical activity for elementary schools, only two (Louisiana and New Jersey) meet the national recommendation of 150 minutes or more per week (commonly "daily physical activity").

Population Served

For the 2006-2007 school year, there were 465,135 Kansas school children enrolled in grades K-12.

Policies aimed at increased physical activity in schools have achieved significant attention in recent years. In 2006, legislation was enacted and signed by the Governor on March 10; this Bill supports PE classes for all grades from K-12 and urges the State Board of Education to require some type of scheduled PE class for grades K-12. In 2007, House Bill 2090 (HB 2090) proposed to require the collection of fitness data on students in grades 4, 7, 9, and 12 in order to benchmark the fitness of Kansas students and guide local and state policymakers. The Bill was heard, but did not pass out of the House Education Committee.

3-51

Physical Fitness and School Health Programs

FAQs

Recommendation:

Strengthen physical education requirements and physical fitness of students for Kansas public schools.

Legislative Action:

$550,728 SGF appropriation.

Summary: Since 1980, obesity rates in the U.S. have more than tripled, making obesity the second greatest threat to the long-term health of children. Based on these factors, it has been projected that one of every three children born in the year 2000 (and one of every two Hispanic children) will develop diabetes during their lifetime. Not only will rising rates of obesity result in a decline in our nation's health, but also an increase in health care costs. By 2020, one of every four dollars will be spent on obesity-related health care treatments. In Kansas, nearly 30% of children aged 10-17 are either overweight or at risk for becoming overweight.

Don't schools already require PE?
Physical Education is currently required at the elementary level, but there is no requirement for daily PE. In addition, PE is not required in middle school. Only one credit of PE, which may include health education, is required for graduation from high school.

What are the benefits of increased physical fitness?
In addition to healthier children, there is a link between physical fitness and test performance. Research shows that standardized test scores improve when health and physical fitness are optimized.

Will increasing physical fitness requirements result in an unfunded mandate for schools?
No, this is not an initiative that would require school compliance. The reform encourages participation by providing schools with the opportunity to apply for funds if they choose to implement a physical fitness program. Through the Kansas Coordinated School Health Program, 224 schools, serving 80,736 students have received funding for physical fitness. Because of this success, this proposal would make funds available for implementation statewide.

CONTINUED

FROM PREVIOUS

How will this policy further recent improvements to physical education and fitness in Kansas public schools?

The recommendation is to meet basic levels of physical activity and physical education (PE) on the Kansas Wellness Policy Builder Part, 3 Physical Activity. The "basic" level recommends that all students K-12 receive a minimum of 100-150 minutes of physical education per week, of which 75 minutes per week (15 minutes per day) is physical activity; the physical education provided is sequential and meets the State Board of Education's teaching standards; is taught by licensed PE teachers with a student/teacher ratio that is consistent with other class sizes in the school; and the school provides a physical and social environment that encourages safe and enjoyable physical activity for students, including those who are not athletically gifted. Details of the "basic" level of wellness guidelines can be found at:

http://www.ksde.org/kneat/SNP/SNPDocs/Wellness/Wellness_Policy_Guidelines_Booklet_Final.pdf

This policy option would utilize the existing Kansas Coordinated School Health grants program. Grants are currently awarded to Kansas schools on a competitive basis to address physical activity, nutrition and tobacco use. However, current funds are able to support activity in only 52 school districts. With additional funding, this proposal would be developed in phases over 5 years. During the first year, 100 school districts will be involved, during the second year, 150 school districts will be involved, during the third year, 199 school districts will be involved, during the fourth year, 248 school districts will be involved and by the fifth year, all 296 Kansas school districts will be served and participating

3-53

Improve Access to Cancer Screening

FAST FACTS

Policy

Increased screenings for breast, cervical, prostate, and colon cancer through expansion of the Early Detection Works (EDW) program.

Background

One of the most significant ways of improving health and decreasing health care costs is to remove barriers to preventive care. Screenings are an effective way to identify those at risk of future disease, or to detect the disease while still in the earliest stages. Disease found early leads to improved efficacy of treatment and decreased long-term morbidity, mortality, and health care costs.

The expense of cancer screening is often raised as a concern. While short-term costs for screening and treatment may rise to a small degree, the long-term savings resulting from treating cancer in its early stages as opposed to costly treatment that accompanies advanced cases will provide for greater cost savings overall. The cost of these screening recommendations pertains only to data addressing need in FY2009. Changes in health care programs, including potential expansions of Medicaid and Premium Assistance programs, may alter funding needs and eligibility levels in future budget cycles.

- Breast and Cervical Cancer. Studies show that breast and cervical cancers that result disproportionately in death among women who are uninsured or underinsured could be significantly reduced by increasing screening rates among at-risk women. Timely mammography screening among women 40 or older may prevent 15% to 30% of all deaths from breast cancer. In Kansas, nearly 400 women die of breast cancer every year, yet access to timely screening could prevent between 60 and 120 of those deaths. If detected early, the survival rate is 90%. The survival rate plummets to 20% when detection is late.

Similarly, cervical cytology or pap smears results in detection

Population Served

All three programs are targeted to those at high clinical risk but lacking the income and insurance resources to access screenings. Expansion of the EDW program at the cost indicated below may allow a total of approximately 7,500 women to be served, which is an increase of 1,700 over the current service population. Funding of a prostate cancer screening program is estimated to serve just over 6,100 men at risk. The colorectal cancer screening effort may provide care for over 12,000 Kansans.

3-54

and treatment of precancerous lesions and cervical cancer at an early stage. In the last five years, an average of 35 women has died annually. Approximately 50% of those deaths would be prevented with adequate screening.

The EDW program is funded by a cooperative agreement between the CDC and KDHE. The program helps low-income, uninsured, and underserved women between the ages of 40 and 64 gain access to lifesaving, early detection screening services for breast and cervical cancers. The EDW program served 7,200 women in FY2006 and an estimated 6,200 Kansas women in FY2007. These results are encouraging but the need is significant. Over 27,000 women may qualify for EDW services in Kansas.

• Prostate Cancer. Prostate cancer is the most common cancer diagnosed in men. More than 1,800 cases are annually diagnosed in Kansas, and 250 men die from prostate cancer each year. Screening for patients at high risk of prostate cancer based on race, age, lifestyle, and family history will result in greatly increased survival rates. While prostate cancer occurs more frequently at age 50, screening should begin at age 40 for those who are at high risk. Based on income, lack of insurance and age, it is estimated that 21,000 men would qualify for prostate cancer screening.

• Colorectal Cancer: Colorectal cancer usually develops from precancerous polyps in the colon or rectum. Screening tests detect precancerous polyps so that they can be removed before becoming cancerous. Screening can also detect colorectal cancer early, when treatment is most effective. Screening should occur for all persons over age 50. In Kansas, an average of 550 persons died each year of colorectal cancer. The CDC indicates that routine screening for colorectal cancer can reduce this number by at least 60%.

3-55

Improve Access to Cancer Screening

FAQs

Recommendation:

Increase screenings for breast and cervical cancer and expand screenings for prostate and colon cancer through the Early Detection Works (EDW) program.

Legislative Action:

$6.6 million SGF appropriation.

Summary: The federal Breast and Cervical Cancer Treatment Act (BCCTA) of 2000 established a federal/state partnership in getting uninsured women access to screening and treatment if necessary. In order to qualify for this program, women must be uninsured or insured with a high, unmet deductible of at least $2,500. They also must fall between the ages of 40-64. Since the program's inception, more than 20,000 Kansas women have been screened. Of these, 500 cases of pre-cancerous and/or invasive breast or cervical cancers have been detected. Over 200 women have received treatment. Because of the successful outcomes of these screenings it is appropriate to expand the program to prostate and colon cancer screenings to save more lives.

Why is an expansion necessary for prostate and colon cancer in Kansas?
Colon cancer is the second leading cancer killer in Kansas. As of 2004, it is estimated that 1480 individuals were diagnosed with colon cancer and 890 died. Despite this grim statistic, the evidence points to very favorable survival rates when it is detected early. In fact, colon cancer is preventable when early detection measures are used. Prostate cancer affects 1900 Kansas men annually, of whom 300 will die. This is also a slow growing cancer that should not prove fatal if detected early.

Will enactment of expanded screenings result in excessive costs for Kansas taxpayers? The initial investment in preventive care will more than offset costly health care services that are necessary in treating late-stage cancer. This is a population that is currently uninsured. If they seek late-stage treatment because screening is unaffordable, there may already be cost-shifting to insured patients that would be alleviated under this program. More importantly, lives will be saved.

Is there a difference in cancer outcomes between the insured and the uninsured?
The American Cancer Society has released a study on this issue in *A Cancer Journal for Clinicians*. Researchers analyzed nearly 600,000 cases from the National Cancer Data Base, as well as a nationwide in-person survey of 40,000 households that the National Center for Health Statistics and the Centers for Disease Control and Prevention conducted. Nearly half of the uninsured either postponed health care or went without due to cost. The researchers found that "for all cancers combined, uninsured patients were 1.6 times as likely to die within 5 years compared to individuals with private insurance." Insured women were twice as likely to get mammograms as the uninsured. The contrast is even greater with colon cancer screenings. Only 19% of the uninsured aged 50-64 got screened, as opposed to 48% of the insured. The data also indicates that the insured are much more likely to be diagnosed in the early stages of cancer.

Increase Medicaid Provider Reimbursement

FAST FACTS

Policy

Analyze and increase specific reimbursement for primary care services consistent with a medical home model and "value-based health care purchasing" for the Kansas Medicaid/HealthWave program.

Background

The concept of value-based health care purchasing is that purchasers should focus on outcomes, cost, and quality of health care through the informed use of health care services. In Kansas, value-based purchasing can focus on incentives for health services delivered through a primary care medical home, thus, reducing inappropriate and inefficient care. The health care system and its patterns of reimbursement currently serve as disincentives for providers to take time to provide those preventive services not associated with a technical procedure. Even those technical procedures associated with prevention activities are often not paid for at the optimal rates. Health care reform should include a commitment to analyze the reimbursement rates of health providers serving beneficiaries of state-funded health plans for a wide range of screening activities and preventive care.

Population Served

The populations served are beneficiaries and health care providers in the Kansas Medicaid/HealthWave program.

Transparency for Consumers: Consumer Health Care Cost and Quality Transparency Project

FAST FACTS

Policy

Support the second phase of the Kansas Consumer Health Care Cost and Quality Transparency Project which will begin to collect and make available existing health and health care data resources to the Kansas consumer.

Background

In FY 2008, KHPA approved a two-phase Health Information Transparency (HIT) Initiative for consumers. In Phase I of this project, the State Library of Kansas is working with other libraries to create a web-based portal of existing health and health care resources for Kansas consumers. The portal is called Kansas Health Online. Access to this information is available from the KHPA website and through the libraries. Kansas Health Online will be marketed to all public libraries in Kansas as "the icon for health care" and training in the use of the Portal commenced after January 1, 2008. The development of the Portal was functionally implemented on January 15, 2008 and will be fully implemented by June 2008. A health information curriculum will also be established to educate Kansans about the use of health information and available health resources.

In Phase II of this Project, Kansas-specific health quality and cost measures recommended to the KHPA Board by the Data Consortium (which consists of health care stakeholders in Kansas) will be developed and made available to consumers through Kansas Health Online, allowing consumers to compare cost and quality of health providers and plans.

Population Served

The population served is all Kansans with access to the Internet or public libraries. The entire population of the state (2,764,075) has access to the public libraries in their community or communities nearby.

KANSAS-SPECIFIC DATA

There are 327 public libraries located across the state of Kansas. The public library system is regionalized into seven districts — Central, North Central, Northeast, Northwest, South Central, Southeast, and Southwest. The public libraries have long served as a focal point in the community for information exchange. Simultaneously, the National Library of Medicine is developing a "Go Local" feature, which brings information about local health care services and support groups to Kansas consumers. The Go-Local feature of this project will localize resources pertinent to the seven library districts.

3-583

Transparency for Consumers:
Consumer Health Care Cost and Quality Transparency Project

FAQs

Legislative Action:

$200,000 SGF included in the FY 2009 KHPA budget

Summary: In FY2008, KHPA approved a two-phase Health Information Transparency (HIT) initiative. The first phase involved the State Library of Kansas working with other libraries to create a web-based portal — called Kansas Health Online — of existing health and health care resources for Kansas consumers. The second phase is to develop Kansas-specific health quality and cost measures and make them available to consumers.

Why is consumer transparency so important?
Consumers currently have limited access to meaningful information from which informed health decisions can be made. As result, there is little assurance that consumers are receiving an optimal return on investment when purchasing health care services. Consumers have access to information for other purchases. When it comes to health, it is critical that information should be available to allow an informed decision. Publishing standard pricing and quality information can empower consumers and purchasers to use resources more efficiently and consider the cost/benefit factor, driving them to providers that offer the highest quality care.

Have other states implemented this type of program?
A number of health information library-driven initiatives are underway across the country to facilitate consumer access to health care information. In 2004, the National Library of Medicine announced that over 40 projects in 24 states were funded to improve consumer access to reliable and authoritative online health information. The American Libraries Association (ALA) also announced their partnership with Wagreen in 2004 to promote consumer health education and libraries as a source of health information. Initial efforts focused on providing public libraries with information to increase knowledge and understanding of the Medicare Drug Discount Card Program. The Medical Library Association (MLA) offers a "User's Guide to Finding and Evaluating Health Information." The guide incorporates the collective wisdom of medical librarians who regularly search the internet for quality information in support of clinical and scientific decision making by doctors, scientists, and other health practitioners. This guide is available at the Kansas Health Online Site http://www.kansashealthonline.org

How will this initiative work in Kansas?
The key to consumer-driven decisions is to make sure that the data is accurate, easy to understand, and accessible. Through the creation of the web portal, access will be available to Kansans using the internet at the 327 libraries located across the state. In Phase II, indicators developed by the Data Consortium, a broad stakeholder advisory panel to KHPA, will be available to consumers through the Health Trasparency Portal. This will allow consumers to compare cost and quality of health providers and plans.

3-59

Promote Insurance Card Standardization

FAST FACTS

Policy

Include a standardized format for health insurance cards for Medicaid/HealthWave beneficiaries and for SEHBP enrollees to decrease administrative costs, improve efficiency, and increase health care coordination.

Background

One-third of every health care dollar is spent on administrative costs, and a lack of standardized electronic health insurance cards contributes specifically to these costs.

Most insured Kansans carry around one or more health insurance cards in their wallet. However, unlike debit cards, credit cards, or even grocery store discount cards, these health insurance cards are not electronic, which results in physician offices investing more time on paperwork, and resources diverted away from patient care. Improving the coordination of health care services will lower administrative costs and is a key component of a medical home.

A health insurance ID card is a patient's entry point into the health care system. A study completed by the Governor's Health Care Cost Containment Commission found that approximately 20% of claims were denied due to inaccurate or incomplete information about a patient's coverage. Presently, ID card technology has advanced to the point that it can be used as a "key" for providers to unlock a patient's financial and insurance eligibility information and reduce errors in claim denial. Not only will the new card save the administrative costs of processing denied claims, it will also make the patient's registration process easier. This information could be accessed via the electronic cards, reducing claim denials that currently result in significant administrative costs for physicians, hospitals, and health plans – costs that are ultimately passed on to patients and employers.

For the Medicaid/HealthWave program, the KHPA currently issues paper ID cards monthly. Under this plan, the KHPA would substitute plastic "advanced ID cards" that utilize a magnetic stripe or bar code technology. These cards will allow a provider the ability to instantly determine if a member qualifies for a Kansas Medical Assistance Program (KMAP) or future program, such as Premium Assistance, by swiping or scanning a patient's card. For the SEHBP, the use of advanced ID cards will be required in future contracts with health plans.

Population Served

The population served is Kansans who qualify for Medicaid/HealthWave and state employees. Kansans participating in the SEHBP will be affected as the KHPA renews contracts with health plans.

3-60

Promote Insurance Card Standardization

FAQs

Recommendation:

Include a standardized format for health insurance cards for Medicaid/ HealthWave beneficiaries and for State Employee Health Benefit Plan (SEHBP) enrollees to decrease administrative costs, improve efficiency, and increase health care coordination.

Legislative Action:

None. $86,000 cost will be absorbed within the existing KHPA budget.

Summary: A study by the Governor's Health Care Cost Containment Commission discovered that around 20% of all medical claims were denied due to inaccurate or incomplete information regarding patient insurance coverage. Modern technology has made it possible for doctor offices to scan insurance cards using magnetic strips or bar codes to store the patient's coverage information. By using electronic "advanced ID cards," health care offices will allow technology to scan these cards for patient information about health insurance coverage and thereby reduce human errors.

How much is spent on administrative costs including processing multiple insurance cards? About one third of every dollar spent on health care in Kansas goes to pay for administrative costs. The purpose of standardizing health insurance cards is to decrease these administrative costs which are incurred by having multiple insurance card formats that are not electronic and promote confusion and mistakes among health care facilities.

How does ID card standardization improve efficiency within health systems?
Standardization can improve efficiency among administrative staff and improve coordination among providers and facilities. While many Kansans have multiple health insurance cards (e.g., health, dental, vision, prescription, etc.), these cards are not electronic. Therefore, physician offices have to spend significant amounts of time on paperwork, which leads to less time providing health care services to their patients.

How will ID Card Standardization Benefit Me Personally?
Due to significant amounts of paperwork, there is less time available for providers to spend with their patients tending to their health care needs. In addition, when claims are incorrectly denied due to inaccurate or incomplete insurance information, these unnecessary administrative costs are passed along to patients and employers who purchase coverage for their workers. Because the three targeted programs, Medicaid, HealthWave, and the State Employee Health Benefit Plan, use state dollars to finance health care costs, all taxpaying Kansans serve to benefit by reduced administrative health care costs.

3-61

Will this Standardization be Universal?

The format of the Advanced ID card is being developed using standards developed by Kansans, soon to be adopted nationally. The standards govern the transmission and receipt of information and focuses on specifications of applying ID card technology to patient ID cards. The KHPA recommendation is for Advanced ID cards to be implemented within State funded programs, Medicaid, HealthWave, and the State Employees Health Benefit Plan and pays for itself within one year. Implementation is also expected to move the market forward with more widespread adoption and utilization of Advanced ID Card technology in Kansas.

How will this be implemented?

Through a multiple stakeholder process (Mid-America Coalition on Health Care funded project), the standards for Advanced ID cards has already been developed. The input provided by this collaborative process has helped to prepare stakeholders for utilization of these ID cards. All beneficiaries will be mailed plastic cards with bar-code technology that will store eligibility information for real-time payment.

3-62

Partnering with Community Organizations

FAST FACTS

Policy

Expand the volume of community-based wellness programs through partnerships between state agencies and community organizations.

Background

Partnerships are the key to develop effective community-based wellness programs. There are many examples of these types of successful partnerships throughout the state. Kansas is in a unique position, in that there are significant foundations within the state with a keen interest in health promotion. This advantage gives Kansas the flexibility to adopt new and innovative strategies to promote health care that are not confined by strict federal funding rules. Kansas can also benefit from the experience of other states. For example, the state of Vermont has developed a successful community engagement strategy aimed at promoting community infrastructure to support healthy lifestyles. Initiatives focus on the built environment (walking trials, bike paths, etc.), physical activity programs in pilot communities, and awarding grants to communities for programs that support chronic disease prevention and management, and developing a toolkit for sharing successful evidence-based projects.

Support for additional organizations can improve health outcomes at the local level. For example, the Kansas Association of Counties (KAC) and the Kansas Association of Local Health Departments (KALHD) are seeking to improve birth outcomes by increasing access to early prenatal care through care coordination services and improved outreach efforts. Other examples of local partnerships:

- Partnerships with Local Health Departments. In 2004, the state of Kansas awarded grants to 36 local health departments to promote healthy eating practices and tobacco use prevention in addition to promoting physical activity initiatives within their communities. Additional training was later provided on using walking paths as catalysts to promote physical activity and better nutrition. Community grants such as these should be continually promoted across the state to provide needed funding for the construction of fitness centers, biking paths, and other wellness activities.

Population Served

The populations served are all residents and visitors to the state of Kansas.

3-63

- Partnerships with business groups. In 2004, the state of Kansas and Mid-America Coalition on Healthcare (MACHC) collaborated to implement a pilot worksite wellness project in the Kansas City metropolitan area involving 14 large and medium-sized employers. The 5-year project consists of four phases focusing on blood pressure, cholesterol, physical inactivity, obesity, poor nutrition, and tobacco use. The unique public-private partnership has engaged employers collaboratively with health plans, health care providers, universities, media, pharmaceutical companies, national researchers and various governmental agencies.

- Partnerships with other state agencies. The Kansas Department of Health and Environment partnered with the Kansas Department of Commerce in 2006 to start a worksite Farmer's Market in downtown Topeka to increase access to fresh, locally grown produce to downtown workers. This Farmer's Market has continued into 2007 with greater success. Similarly, the KHPA could partner with Kansas Department of Aging's (KDOA) successful STEPS program to encourage physical activity among seniors, Farmer's Market voucher initiative, and the Lifelong Communities program promoting successful aging among seniors.

- Partnerships with faith communities. The state of Kansas partners with the Center for Health and Wellness (CHW) to provide community-based hypertension reduction activities in African American churches in Sedgwick County. The program targets undiagnosed cases of hypertension and refers those identified clients for treatment. Monthly blood pressure screenings are conducted in over 35 churches and senior centers. Other faith-based partnerships in Kansas include the United Methodist Healthy Congregation program, providing technical assistance to United Methodist churches to develop a health plan for their congregations.

3-64

Partnering with Community Organizations

FAQs

Recommendation:

Expand the volume of community-based wellness programs through partnerships between state agencies and community organizations.

Legislative Action:

None.

Summary: Successful partnerships are key to the development of effective community-based wellness programs and improving health outcomes locally. These partnerships involve more than government entities. They involve cooperation between the local business community and the faith community to succeed. The Centers for Disease Control (CDC) has long valued these partnerships and has invested in them in Kansas.

What are some examples of state/local partnership opportunities?
The Kansas Association of Counties and the Kansas Association of Local Health Departments have proposed working together to improve birth outcomes through increased access to prenatal care services.

What about business partnerships?
In 2004, the Mid-America Coalition on Healthcare partnered with the state to implement a pilot worksite wellness project in the Kansas City metropolitan area that focuses on addressing blood pressure, cholesterol, physical inactivity, obesity, poor nutrition, and tobacco use. This 5-year pilot project was implemented in 14 large and medium-sized employers.

What about state agency cooperation?
In 2006, the Kansas Department of Health and Environment and the Kansas Department of Commerce started the worksite Farmer's Market in downtown Topeka to increase access to fresh and locally grown produce to downtown workers, which continued into 2007 with even greater success.

Are there examples within the faith community?
Kansas also partners with faith based communities; the Center for Health and Wellness works with African American churches in Sedgwick County to reduce hypertension.

3-65

Collect information on Health/Fitness of Kansas School Children

FAST FACTS

Policy

Support the establishment of a state-based surveillance system to monitor trends of overweight, obesity, and fitness status on all public school-aged children in Kansas, as recommended by Governor's Council on Fitness.

Background

Obesity has become the second greatest threat to the long-term health of children, second only to tobacco. The percentage of young people who are overweight has more than tripled since 1980. As a result, it is projected that one of every three children born in 2000 (and one of every two Hispanic children) will develop diabetes in their lifetime. By 2020, one of every four dollars spent on health care will be used for obesity-related treatments. Data on childhood obesity in Kansas is currently gathered through surveys. While the current method of self-reporting gives the state a subjective view of the issue, data is lacking on the demographics of the children most affected. The lack of information means that programs are unable to appropriately target the most vulnerable populations in a cost-effective manner. Schools will need assistance in implementing this policy, as they expressed concern with loss of instructional time to perform the measurements, and with the time and fiscal costs of instituting such a program.

Population Served

For the 2006-2007 school year, there were 465,135 Kansas school children enrolled in grades K–12.

3-66

Collect information on Health/Fitness of Kansas School Children

FAQs

Recommendation:

Collect information on health and fitness of Kansas school children.

Legislative Action:

None.

Summary: Since 1980, obesity rates in the U.S. have more than tripled, making obesity the second greatest threat to the long-term health of children. Based on these factors, it has been projected that one of every three children born in the year 2000 will develop diabetes during their lifetime. In 2007, HB 2090 was introduced which would require the collection of fitness data on students in grades 4, 7, 9, and 12 in order to benchmark the fitness of Kansas students and guide local and state policymakers. The legislation did not pass.

What is the cost of obesity?
By 2020, one of every four dollars will be spent on obesity-related health care treatments.

What are the obesity rates for Kansas children?
Nearly 30% of Kansas children aged 10-17 are either overweight or at risk for becoming overweight. Currently, data on childhood obesity is collected through self-reported surveys, which is subject to misrepresentation and misclassification of overweight and obesity.

How will collecting fitness and weight measurements promote health prevention? In order to get a true picture of the occurrence and demographics of obesity among our children, an objective measurement collection must be utilized. By obtaining accurate data, we can appropriately target the most vulnerable populations in a cost-effective manner.

Which communities already collect health and fitness measurements?
Historically, there has been no systematic reporting for which schools collect health and fitness information, but a growing number of schools statewide indicate they have begun to measure Body Mass Index (BMI) and fitness of their students. What we know about current school practices with regard to collecting BMI is from anecdotal reports or from program progress reports from grantees. The Coordinated School Health (CSH) Program has a direct relationship with 43 school district grantees and of the 22 districts that have responded to a survey about collecting this information, 16 indicated they are collecting BMI measures. The grantees collecting BMI on students in some form include: Atchinson County Community Schools, Buhler, Dighton, Dodge City, Fort Scott, Greiffenstein, Goddard, Hoisington, Holcomb, Maize, Parsons, Sacred Heart, Scott City, Seaman, Sterling Grade School, and Ulysses.

The Kansas Department of Health and Environment (KDHE) has successfully collected self-reported height and weight data on a random sample of students in grades 6-12 as part of the YTS (Youth Tobacco Survey). Additionally, KDHE and the Kansas Department of Education (KSDE) jointly administer the Youth Risk Behavior Survey (YRBS) to a random sample of high school students, grades 9-12. This survey provides state estimates on the prevalence of common health risk factors for adolescents including, but is not limited to, physical activity, nutrition, and tobacco use.

Is the collection of this data an unfunded mandate to schools? This proposal does not require school participation, it encourages it. According to a study by the Kansas State Department of Education (KSDE) and the Kansas Health Institute (KHI), more than 80% of public school and school district staff support the collection of BMI.

3-68

Promote Healthy Food Choices in Schools

FAST FACTS

Policy

Adopt policies that encourage Kansas school children to select healthy food choices in school by competitively pricing and marketing these foods and restricting access to foods with little or no nutritional value.

Background

Childhood obesity rates are climbing at an alarming pace. In Kansas, 14% of children aged 10-17 are overweight (Kaiser State Health Facts – Data based on the National Survey of Children's Health). Another 14% are at risk for becoming overweight (Youth Risk Behavior Surveillance System Data). Measures should be taken to reverse this trend through the adoption of school policies that encourage healthy eating.

Many students have access to vending machines and a la carte menus that facilitate unhealthy food choices. In Kansas, 45% of school food service programs offer a la carte items. Over 90% of public high school students have access to vending machines. Some of the most common purchases are soda, chips, and candy. As greater emphasis is placed on individual responsibility in adopting healthy behaviors, consideration must be given to support children and provide an environment of making healthy food at school a priority.

Policy initiatives in schools are recommended that support implementation of the Kansas School Wellness Policy Model Guidelines for Nutrition (Guidelines). The Guidelines provide recommendations to improve the nutritional quality of all foods and beverages available to students on school premises throughout the school day by addressing competitive pricing and promotion of healthy foods, portion size limitations, restricting access to foods of minimal nutritional value; all of which are effective strategies in reducing amount of soda consumed per week, increasing purchases of fruits, vegetables, and low-fat foods, and reducing overall energy intake.

Population Served

For the 2006-2007 school year, there were 465,135 Kansas school children enrolled in grades K-12.

Because school districts may utilize vending and other competitive foods sales revenue to support extracurricular activities in the face of decreased funding from other sources, it is important to change the food options to those that are nutritious. Studies have generally demonstrated positive or neutral fiscal results when contents of school vending machines have been changed to provide more healthy choices.

3-69

Promote Healthy Food Choices in Schools

FAQs

Legislative Action:

None.

Summary: Since 1980, obesity rates in the U.S. have more than tripled, making obesity the second greatest threat to the long-term health of children. Based on these factors, it has been projected that one of every three children born in the year 2000 (and one of every two Hispanic children) will develop diabetes during their lifetime. Not only will rising rates of obesity result in a decline in our nation's health, it means that our health care costs will increase. By 2020, one of every four dollars will be spent on obesity-related health care treatments.

In Kansas, nearly 30% of children aged 10-17 are either overweight or at risk for becoming overweight. Because children are at school for a large portion of the day and are beginning to form habits of health and nutrition that will impact the rest of their lives, targeting food options available in schools allow children an opportunity to form healthier eating habits.

Currently, 45% of Kansas schools offer a la carte items and over 90% of high schools have vending machines that students can access. The most common purchases from vending machines and a la carte lunches include sodas, chips, and candy that are high in calories but low in nutritional value.

Will access to healthier foods change behaviors?
Children, like adults, make food choices based on what is available, affordable, and convenient. Students are eating lunch at school, which is why the offering of nutritious food and restricting access to non-nutritional food is so critical. If the vending machine and a la carte menu are not as accessible, children are left with healthier lunch choices that will redefine one of three meals that they eat. We establish many of our habits and behaviors as children and reinforcing healthy eating behaviors in school is a way to develop lifelong healthy eating habits.

Don't parents impact food behaviors more than schools?
Schools do not take the place of parents modeling healthy eating habits. What schools can do is reinforce, through healthy food offerings, what parents may already be doing at home. Currently, nearly four of every five Kansas students do not meet the FDA recommendation of eating five fruits and vegetables a day. If families and schools work together, this trend may improve.

Will there be a financial impact to schools?
School districts may utilize vending and other competitive food sales revenue to support extracurricular activities. Studies indicate that the financial impact of offering healthy choices in schools is neutral or positive.

3-70

Improve Food Choices in State Cafeterias and Vending Machines

FAST FACTS

Policy

Expand healthy food choices in state agency cafeterias and vending machines. State government has an opportunity to lead by example by providing greater in-house healthy food selections for employees.

Background

Obesity is a key contributor of many chronic diseases, including some cancers, cardiovascular disease, and diabetes. Both nationally and locally, obesity rates have increased sharply in the past 20 to 30 years (Figure 6). According to the Centers for Disease Control and Prevention (CDC), the obesity rate among adults aged 20-74 increased from 15% of the population in 1976 to 33% of the population in 2003-2004. The estimated total cost of obesity in the US as of 2000 was approximately $117 billion.

These statistics are even more sobering in Kansas. In 2006, over 36% of adults were overweight and nearly 26% were obese. Obesity has increased since 2000 when 21% of adult Kansans were obese. Promoting regular physical activity and healthy eating and creating an environment that supports these behaviors are essential to addressing the problem. Research shows that good nutrition can help to lower risk for many chronic diseases, including heart disease, stroke, some cancers, diabetes, and osteoporosis. However, a large gap remains between healthy dietary patterns and what Americans actually eat. In 2005, only one-fourth of US adults ate 5 or more servings of fruits and vegetables each per day. In Kansas as of 2000, 23% of adults consumed 5 servings of fruits and vegetables per day. This proportion has since declined with less than 20% of adult Kansans meeting recommended levels of fruit and vegetable consumption in 2005. Providing more healthy food options in state cafeterias and vending machines at competitive prices might begin to reverse current trends.

Other states have utilized state government as a starting point for healthy eating options. One program is Arkansas' chronic disease plan in which approximately 10,000 state employees completed the Healthy Employees Lifestyle Program (HELP) pilot. The Arkansas Department of Health provides nutrition related information to its vendors in order to promote stocking vending machines with healthier options. They also have a worksite wellness program "Fit with 5" that encourages workers to get the recommended levels of physical activity of 30 minutes on five or more days of the week and to eat five fruits and vegetables every day.

Population Served

On Oct. 5, 2007 there were 38,130 full-time and 3,416 part-time employees (total of 41,546). Other populations impacted would include contract workers and employee guests who frequently visit state agency facilities.

3-71

Improve Food Choices in State Cafeterias and Vending Machines

FAQs

Recommendation:

Provide healthy food choices in the cafeterias and vending machines to state employees.

Legislative Action:

None.

Summary: In 2006, over 36% of Kansas adults were overweight and 26% were obese. Kansas is no exception to escalating obesity trends that have more than doubled in the last thirty years. Our obesity rates have increased 10% since 2001. Nationally, 15% of the population fell into the obese category in 1976, compared to 33% in 2004. Engaging in physical activity and healthy eating are the ways to reverse this trend. As of 2000, 23% of Kansas adults ate five servings of fruits and vegetables daily. This proportion dropped to only 20% in 2005. Not only are we not eating enough of the right foods, but portion sizes have increased simultaneously.

Why target state employees?
State employees comprise a substantial portion of the workforce in Kansas. Providing this population with the food choices that enable a healthy lifestyle sets an example for other employers to follow our lead and improve worker health outcomes. Reversing obesity trends result in taxpayer savings as state employee health costs decline.

What are the health outcomes associated with obesity?
Many chronic conditions result from obesity including heart disease, stroke, some cancers, diabetes, and osteoporosis. These conditions come with a steep price tag for everyone. Nationally, the estimated total cost of obesity was $117 billion in 2000.

Are healthy foods just a matter of sufficient selection?
No, there is also a cost component. Healthy foods must be available at an affordable price. In other words, it should not cost less to buy a cheeseburger and fries than a salad in the cafeteria.

Are other states offering healthy choices?
Arkansas has implemented a comprehensive approach to nutrition and exercise through the Healthy Employees Lifestyle Program (HELP) pilot. The Arkansas Department of Health provides nutrition- related information to its vendors to promote stocking vending machines with healthier options. Approximately 10,000 state employees participated in HELP.

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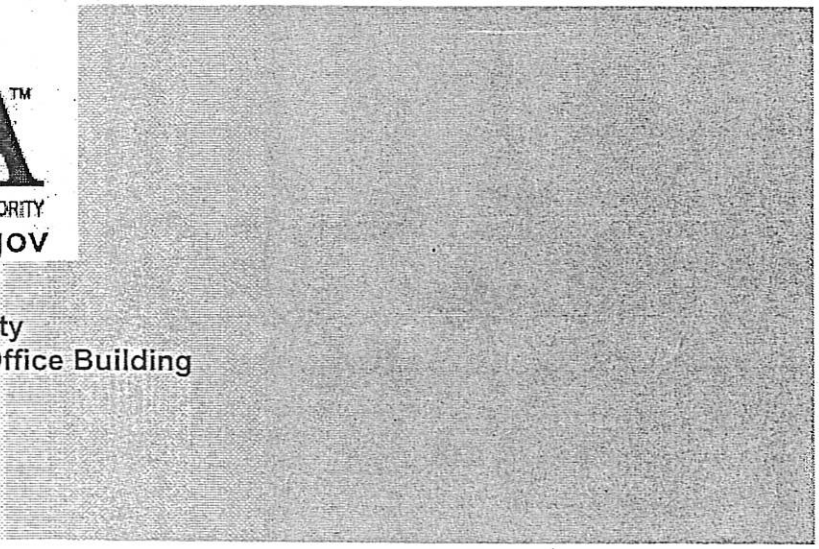

3-73

2008 Federal Poverty Guidelines*

Federal Poverty Percentage	Household Size 1	2	3	4	5
27.5%	$ 2,860	$ 3,850	$ 4,840	$ 5,830	$ 6,820
37%	3,848	5,180	6,512	7,844	9,176
50%	5,200	7,000	8,800	10,600	12,400
75%	9,750	13,125	16,500	19,875	23,250
100%	10,400	14,000	17,600	21,200	24,800
125%	13,000	17,500	22,000	26,500	31,000
133%	13,832	18,620	23,408	28,196	32,984
150%	15,600	21,000	26,400	31,800	37,200
185%	19,240	25,900	32,560	39,220	45,880
200%	20,800	28,000	35,200	42,400	49,600

For each additional person in the household add $3,600 for 100% of FPL.

* from U.S. Department of Health and Human Services (www.aspe.hhs.gov). Figures are for the 48 contiguous states and D.C..

Note: The HHS poverty guidelines, or percentage mulitples of them (such as 125 percent etc.) are used as an eligibility criterion by a number of federal programs including Head Start, Food Stamps, National School Lunch Program, Low-Income Home Energy Assistance, Children's Health Insurance Program and some parts of the Medicaid program. In general, cash public assistance programs do not use these poverty guidelines in determining elibility. A more detailed list of programs that use or do not use these guidelines can be found at www.aspe.hhs.gov.

Senate Health Care Strategies Committee
Date: February 18, 2008
Attachment 4

Table 6

Medicaid Income Eligibility as a Percent of Federal Poverty Level (FPL), 2006

State	Infants	Children 1-5	Children 6-19	Pregnant Women	Parents	
					Non-Working	Working
Alabama	133%	133%	100%	133%	12%	26%
Alaska	175%	175%	175%	175%	76%	81%
Arizona	140%	133%	100%	133%	200%	200%
Arkansas	200%	200%	200%	200%	15%	18%
California	200%	133%	100%	200%	100%	107%
Colorado	133%	133%	100%	200%	60%	67%
Connecticut	185%	185%	185%	185%	150%	157%
Delaware	200%	133%	100%	200%	100%	107%
District of Columbia	200%	200%	200%	200%	200%	207%
Florida	200%	133%	100%	185%	22%	58%
Georgia	200%	133%	100%	200%	31%	55%
Hawaii	300%	300%	300%	185%	100%	100%
Idaho	133%	133%	100%	133%	23%	43%
Illinois	200%	133%	133%	200%	185%	192%
Indiana	150%	150%	150%	150%	21%	27%
Iowa	200%	133%	133%	200%	31%	77%
Kansas	150%	133%	100%	150%	29%	36%
Kentucky	185%	150%	150%	185%	38%	66%
Louisiana	200%	200%	200%	200%	14%	20%
Maine	200%	150%	150%	200%	200%	207%
Maryland	200%	200%	200%	250%	31%	38%
Massachusetts	200%	150%	150%	200%	133%	133%
Michigan	185%	150%	150%	185%	38%	61%
Minnesota	280%	275%	275%	275%	275%	275%
Mississippi	185%	133%	100%	185%	27%	33%
Missouri	300%	300%	300%	185%	21%	40%
Montana	133%	133%	100%	133%	35%	62%
Nebraska	185%	185%	185%	185%	46%	58%
Nevada	133%	133%	100%	185%	25%	86%
New Hampshire	300%	185%	185%	185%	45%	56%
New Jersey	200%	133%	133%	200%	115%	115%
New Mexico	235%	235%	235%	185%	28%	65%
New York	200%	133%	100%	200%	150%	150%
North Carolina	200%	200%	100%	185%	39%	54%
North Dakota	133%	133%	100%	133%	38%	65%
Ohio	200%	200%	200%	150%	90%	90%
Oklahoma	185%	185%	185%	185%	34%	43%
Oregon	133%	133%	100%	185%	100%	100%
Pennsylvania	185%	133%	100%	185%	30%	61%
Rhode Island	250%	250%	250%	250%	185%	192%
South Carolina	185%	150%	150%	185%	48%	97%
South Dakota	140%	140%	140%	133%	58%	58%
Tennessee	185%	133%	100%	185%	70%	80%
Texas	185%	133%	100%	185%	14%	29%
Utah	133%	133%	100%	133%	42%	49%
Vermont	300%	300%	300%	200%	185%	192%
Virginia	133%	133%	133%	166%	24%	31%
Washington	200%	200%	200%	185%	39%	79%
West Virginia	150%	133%	100%	150%	18%	36%
Wisconsin	185%	185%	185%	185%	185%	192%
Wyoming	133%	133%	100%	133%	43%	57%

Source: "Resuming the Path to Health Coverage for Children and Parents: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006," a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, January 2007. Available at http://www.kff.org/medicaid/7608a.cfm.

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< Back to previous page

Medicaid Enrollment as a Percent of Total Population, 2004

Bar Graph | Table | Map | Map & Table

Rank by: State name (alphabetical)

Rank Order: ▲▼

	Medicaid Enrollment as a % of Total Pop
United States	20% [1]
Alabama	20%
Alaska	19%
Arizona	24%
Arkansas	25%
California	30%
Colorado	12%
Connecticut	15%
Delaware	20%
District of Columbia	28%
Florida	17%
Georgia	22%
Hawaii	18%
Idaho	16%
Illinois	19%
Indiana	16%
Iowa	14%
Kansas	13%
Kentucky	20%
Louisiana	25%
Maine	24%
Maryland	15%
Massachusetts	18%
Michigan	18%
Minnesota	15%
Mississippi	27%
Missouri	21%
Montana	13%
Nebraska	15%
Nevada	11%
New Hampshire	11%
New Jersey	13%
New Mexico	27%
New York	25%
North Carolina	19%
North Dakota	12%
Ohio	17%
Oklahoma	19%
Oregon	17%
Pennsylvania	15%
Rhode Island	20%
South Carolina	24%
South Dakota	16%
Tennessee	28% [2]
Texas	17%
Utah	14%
Vermont	27%
Virginia	12%
Washington	19%
West Virginia	21%
Wisconsin	18%
Wyoming	16%
Guam	NA
Puerto Rico	NA
Virgin Islands	NA

Notes: Medicaid enrollment is based on data for FY2004. Population data estimates for July 1, 2004.

KANSAS ACADEMY OF FAMILY PHYSICIANS
CARING FOR KANSANS

February 18, 2008

To: Senate Health Care Strategies Committee
From: Michael L. Kennedy, MD, President
Re: SB 541

Chairwoman Wagle and Members of the Senate Health Care Strategies Committee:

Thank you for this opportunity to present testimony on behalf of the Kansas Academy of Family Physicians (KAFP), regarding SB 541. My name is Mike Kennedy and I am President of the Kansas Academy of Family Physicians. Our organization has over 1,500 members across the state. The family physicians of the state provide the backbone of primary care in Kansas.

The concept of the patient-centered medical home is a priority of KAFP. I am here today to urge you to support SB 541, with an amendment to include this definition of the medical home:

> *The State of Kansas shall develop and implement the medical home to provide comprehensive primary health care for its citizens, as outlined in the document "Joint Principles of the Patient-Centered Medical Home" (February 2007).*
>
> *The medical home is a physician-directed medical practice utilizing a team approach with a whole-person orientation, providing accessible, continuous and comprehensive care, to coordinate patients' needs across the health care system, and improve quality and health outcomes in a cost effective manner.*

All of the evidence that has been gathered on the effectiveness of the medical home—and there is a wealth of it—is based upon health care settings that are physician-directed. (References are noted at the end of the testimony.) We worked with the Kansas Medical Society to draft this statement and believe the statutory definition should reflect the definition upon which the evidence is based.

The proven concept of the medical home is this: care which is managed and integrated by a primary care physician, working with a team of health care professionals, will lead to the best health outcomes for patients. It is centered on the needs of the patient and provides personalized care, access beyond acute care episodes, and integration of key medical and community resources to meet patients' needs. Information technology is often used to enhance the quality of care and its measurement in the medical home.

Last year our parent organization, the American Academy of Family Physicians, along with the American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association developed together and released the *Joint Principles of the Patient-Centered Medical Home*. It is significant to have the four organizations dedicated to primary care come together on a national level to define the principles guiding this concept. We also believe it is very important to reference this key document in the statutory definition.

Senate Health Care Strategies Committee
Date: February 18, 2008
Attachment 5

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The US health care system currently performs at a level considerably below its potential: despite spending more on health care than any other nation, the United States does not have the best health care or the most effective health care system. Payers and patients alike are looking for better value in health care, desiring better quality of care for less cost.[4] A recent study estimated that if every American had a medical home, health care costs would likely decrease by 5.6 percent, resulting in national savings of $67 billion dollars per year, with an improvement in the quality of the health care provided.[5]

Primary care is essential for the effective and efficient functioning of America's health care delivery system. The value of primary care to reduce overall healthcare spending while improving quality and patient outcomes has been consistently proven.[6-12] Primary care is uniquely positioned as a portal between people and the most costly services of the healthcare system.[1] Primary care physicians receive everyone and make the decision to treat or send patients for the appropriate level of care. There must be a balance in the organization and finance of health care to fully recognize the importance of primary care to our nation's health. Primary care is an underutilized resource that when used appropriately is an effective means of cost-efficient high quality medical care.

The Commonwealth Fund 2006 Health Care Quality Survey [20] finds that when adults have health insurance coverage and a medical home—defined as a health care setting that provides patients with timely, well-organized care, and enhanced access to providers—racial and ethnic disparities in access and quality are reduced or even eliminated. When adults have a medical home, their access to needed care, receipt of routine preventive screenings, and management of chronic conditions improve substantially. The survey found that rates of cholesterol, breast cancer, and prostate screening are higher among adults who receive patient reminders, and that when minority patients have medical homes, they are just as likely as whites to receive these reminders.

Chronic illness management and patient education and support are central themes in the Medical Home. Patients with similar problems could participate in group visits led by physicians or other team members. The peer support and other unique dynamics of groups have proved beneficial for patients and providers while improving patient outcomes.[13-16]

The medical home will provide multiple access points for patients. Open scheduling will allow walk-ins and same-day appointments. Interactive websites will allow patients to access test results, correspond with their care team, request prescription refills, schedule appointments, and access their medical record. Technology will move patient self management to exciting new levels by giving patients resources for disease management and health education.

The adoption of an electronic health record (EHR) is important to the medical home. It is well understood that measurement is essential for quality improvement. Currently we collect this data primarily from chart reviews and claims data which is inaccurate and costly. Through the technology afforded in better EHRs, prospective data collection becomes a reality providing the physician and payers with real-time quality measures for the purpose of benchmarking, improvement, and payment.

One flaw in the current system is that payment is dependent on expensive and time consuming face-to-face visits. Needs for care do not end at an individual physician's door. The Medical Home will be able to offer online consultations and group visits which create efficiencies that should lower the cost of care for most patients while affording physicians more time to provide the quality care their patients and payers deserve. For this to work, fundamental reform that provides comprehensive payment for comprehensive care is necessary. [17]

The Medical Home is designed to expand options for patients through care coordination, enhanced access, and information technology. The personal physician of choice, who has comprehensive knowledge of the patient's conditions, integrates care with all the subspecialists involved in the patient's care. In the medical home, care management is blended with fee-for-service. The payment for services to coordinate care would be contingent on negotiated levels of performance in both cost savings and quality improvements with the individual payers.

North Carolina's Medicaid program shows excellent quality and cost outcomes after adopting several components of the Medical Home in their Community Care of North Carolina (CCNC) program. Through disease management payments, evidence-based clinical practice, and an emphasis on a team approach for case management they found significant improvements in cost, utilization, and quality measures. The program consists of an additional $5 per-member per-month case management fee, and an enhanced fee-for-service payment of 95 percent of the Medicare fee schedule for Medicaid covered services. Two major evaluations of this program estimated that it saved the state $195 to $215 million in 2003 and between $230 and $260 million in 2004.[19]

KAFP brought in a consultant from North Carolina to discuss the issues with Dr. Nielsen and her senior staff in late August last year and appreciated the opportunity to provide his services for the consultation.

Last November the Council on State Governments unanimously passed a resolution supporting the Patient –Centered Medical Home and urging states to implement and fund pilot programs to demonstrate the quality, safety, value and effectiveness of the patient-centered medical home. I have included a copy of that resolution and summary at the end of the testimony.

Physicians can be evaluated and get a designation for providing a medical home to patients. The National Committee for Quality Assurance (NCQA) is a well-known and recognized non-profit organization dedicated to improving health care quality. NCQA sets forth standards based upon the Joint Principles that designate various levels of the Patient Centered Medical Home. A physician can apply to be evaluated by NCQA as to how well they meet the standards, and what level of the Medical Home they provide.

At the request of the KHPA, we are working with the Kansas Medical Society to distill the definition of the medical home down to two sentences that would be appropriate to include in legislation. We have reached agreement with KMS about that definition, but have not had a chance yet to provide it to the KHPA.

Thank you for your consideration. I'd be happy to stand for any questions you might have.

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American Academy of Family Physicians (AAFP)
American Academy of Pediatrics (AAP)
American College of Physicians (ACP)
American Osteopathic Association (AOA)

Joint Principles of the Patient-Centered Medical Home
February 2007

Introduction

The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth and adults. The PC-MH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PC-MH.

Principles

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care

planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.

- Evidence-based medicine and clinical decision-support tools guide decision making
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.

- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

Background of the Medical Home Concept

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the "medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006).

For More Information:

American Academy of Family Physicians
http://www.futurefamilymed.org

American Academy of Pediatrics:
http://aappolicy.aappublications.org/policy_statement/index.dtl#M

American College of Physicians
http://www.acponline.org/advocacy/?hp

American Osteopathic Association
http://www.osteopathic.org

THE COUNCIL OF STATE GOVERNMENTS
RESOLUTION ON THE PATIENT-CENTERED MEDICAL HOME

Resolution Summary

The Patient-Centered Medical Home (PCMH) is a health care delivery model designed to improve health, promote quality, and reduce the cost of health care that is centered primarily and explicitly on the needs of the patient. The PCMH is personalized care, access beyond the acute care episode, and integration of key medical and community resources to meet patient needs.

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for medical records of a child to be archived. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally sensitive care.

In 2007, the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association—organizations dedicated to primary care representing more than 333,000 physician members—released the *Joint Principles of the Patient-Centered Medical Home*, with the following characteristics:

- **Relationship**: Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care

- **Team**: The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of the patients.

- **Comprehensive**: The personal physician is responsible for providing for all the patient's health care needs at all stages of life or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute, chronic, mental health, preventative, and end of life.

- **Integration**: Care is coordinated and integrated across all domains of the health care system and the patients' community. Care is facilitated by registries, information technology, and information exchange to assure that patients get the indicated care when and where they want it.

- **Quality and Safety**: Quality and Safety are hallmarks of the medical home. Through electronic medical records and technology providing decision-support physicians will be able to provide their patients with the most up-to-date evidence-based treatment options. This technology will facilitate physicians' ability to participate in measurement and quality improvement activities at the practice and system level.

- **Access**: Enhanced access to care is available through systems such open scheduling, expanded hours, and new options for communication between patients, physicians, and practice staff.

- **Value**: Payment is aligned to appropriately recognize the added value provided to patients who have a PCMH.

What does the PCMH look like?

Primary care is a complex set of tasks managed by a multidisciplinary team. This team works together to create high quality, personalized, integrated, comprehensive, accessible care that is safe and affordable.

The PCMH takes this care to a more personal level. For example, PCMH practices will ensure multiple access points for patients. Open scheduling will allow walk-ins and same-day appointments. Interactive Web sites will allow patients to access test results, correspond with their care team, request prescription refills, schedule appointments, and access their medical record. Technology will move patient self management to exciting new levels by giving patients resources for disease management and health education.

It is understood that measurement is essential for quality improvement. Through the technology afforded in EHRs, prospective data collection becomes a reality providing the physician and payers with real-time quality measures for the purpose of benchmarking, improvement and payment. The PCMH will offer online consultations and group visits which create efficiencies that should lower the cost of care for most patients while affording physicians more time to provide the quality care their patients and payers deserve.

The North Carolina's Medicaid program shows excellent quality and cost outcomes after adopting several components of the PCMH in their Community Care of North Carolina (CCNC) program. Through disease management payments, evidence-based clinical practice, and an emphasis on a team approach for case management they found significant improvements in cost, utilization, and quality measures. The program provides an additional per-member per-month case management fee, and an enhanced fee-for-service payment of 95 percent of the Medicare fee schedule for Medicaid covered services. Two major evaluations of this program estimated that the state saved $195 to $215 million in 2003 and between $230 million and $260 million in 2004 as compared to an alternative payment method (Wilson, C.F.). In recognition of this collaborative approach to meeting the health care needs of low-income children and families, the Ash Institute for Democratic Governance and Innovation at Harvard University's John F. Kennedy School of Government presented the Community Care of North Carolina Program with the "Innovations in American Government Award" on Sept. 25, 2007.
The PCMH aims to deliver the high level of practice outlined by the Institute of Medicine in *Crossing the Quality Chasm*. Primary care physicians recognize that they must transform their practices to provide better value for payers and even better care for patients. Evidence-based public policy will help facilitate the transformation of their practices into PCMHs.

The Commonwealth Fund 2006 Health Care Quality Survey finds that when adults have health insurance coverage and a medical home—defined as a health care setting that provides patients with timely, well-organized care, and enhanced access to providers—racial and ethnic disparities in access and quality are reduced or even eliminated. When adults have a medical home, their access to needed care, receipt of routine preventive screenings, and management of chronic conditions improve substantially. The survey found that rates of cholesterol, breast cancer, and prostate screening are higher among adults who receive patient reminders, and that when minority patients have medical homes, they are just as likely as whites to receive these reminders. The results suggest that all providers should take steps to create medical homes for patients. Community health centers and other public clinics, in particular, should be supported in their efforts to build medical homes for all patients.

The United States health care system currently performs at a level considerably below its potential despite spending more on health care than any other nation. The United States does not have the best health care or the most effective health care system. Payers and patients alike are looking for better value in health care, desiring better quality of care for less cost. A recent study estimated that if every American had a medical home, health care costs would likely decrease by 5.6 percent, resulting in national savings of $67 billion dollars per year with improvement in the quality of the health care provided (Spann, S.J.).

With the enactment in 2006 of the *Tax Relief and Health Care Act*, CMS will implement a three-year medical home model demonstration project in eight states. The project recognizes the medical home provides guidance to both the patient and other health care professionals based on an integrated, coherent plan for ongoing medical care developed specific to the patient. The medical home model should result in improved coordination of care, better care management, a decrease in duplicative tests and avoidance of hospitalizations for all patients, but especially for those patients with one or more chronic conditions, thus resulting in health system savings.

Resources

American Academy of Family Physicians
http://www.futurefamilymed.org

American Academy of Pediatrics:
http://aappolicy.aappublications.org/policy_statement/index.dtl#M

American College of Physicians
http://www.acponline.org/advocacy/?hp

American Osteopathic Association
http://www.osteopathic.org

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Patient-Centered Medical Home Program Management Directives

Management Directive #1: CSG staff will prepare correspondence to Governors and legislative leadership in the states, District of Columbia and territories notifying them of the approved resolution and encouraging them to implement and fund pilot programs to demonstrate the quality, safety, value, and effectiveness of the patient-centered medical home.

Management Directive #2: CSG staff will post approved resolution on CSG's Web site and make available through its regular communications venues CSG support of the Joint Principles of the Patient-Centered Medical Home as a guideline for states, the District of Columbia and territories to improve the health of its citizens.

THE COUNCIL OF STATE GOVERNMENTS
Resolution on the Patient-Centered Medical Home

WHEREAS, the patient-centered medical home provides a whole-person orientation that includes care for all stages of life, acute care, chronic care, preventive services, and end of life care; and

WHEREAS, patients in a patient-centered medical home actively participate in decision-making and feedback is sought to ensure patients' expectations are being met; and

WHEREAS, care in the patient-centered medical home is integrated across all elements of the health care system and the patients' community to assure that patients received the indicated care when and where they need in a culturally and linguistically appropriate manner; and

WHEREAS, when minorities have a medical home, racial and ethnic differences in terms of medical access disappear as noted in "Closing the Divide: How Medical Homes Promote Equity in Health Care" as published by the Commonwealth Fund (June 2007): and

WHEREAS, four national physician organizations (AAP, AAFP, ACP, AOA) representing more than 333,000 physicians across the country have developed joint principles that describe the characteristics of the patient-centered medical home; and

WHEREAS, The National Committee for Quality Assurance is developing a patient-centered medical home designation program for physician practices meeting specific criteria; and

WHEREAS, a patient-centered medical home for every American has a potential national savings of $67 billion per year with improvement in the quality of health care provided; and

WHEREAS, the federal *Tax Relief and Health Care Act* calls for a three-year medical home demonstration project to be conducted in eight states with an estimated start in 2009;

BE IT THEREFORE RESOLVED, that the Council of State Governments support the Joint Principles of the Patient-Centered Medical Home as a guideline for states to improve the health of its citizens, and

BE IT FURTHER RESOLVED, that the Council of State Governments encourage states to implement and fund pilot programs to demonstrate the quality, safety, value, and effectiveness of the patient-centered medical home.

Adopted this 14th Day of November, 2007 at the
CSG Annual State Trends and Leadership Forum
in Oklahoma City, Oklahoma

Governor Brad Henry
2007 CSG President

Representative Deborah Hudson
2007 CSG Chair

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To: Senate Health Care Strategies Committee

From: Jerry Slaughter
Executive Director

Date: February 18, 2008

Subject: SB 541; Concerning Health Reforms Proposed by the Kansas Health Policy Authority

The Kansas Medical Society appreciates the opportunity to appear in support of the health care reform proposals contained in SB 541 which were developed by the Kansas Health Policy Authority (KHPA). As we did when we commented on the proposed reforms at the meeting of the Joint Committee on Health Policy Oversight last November, we would like to commend the KHPA on the public process it undertook to identify and develop the reform recommendations contained in this legislation, as well as the other bills which contain the balance of the KHPA recommendations. The KHPA went to great lengths to obtain the input from stakeholder groups and the public prior to making its recommendations. In addition, the KHPA made a commitment to transparency in its deliberative process, and much of the testimony and reports which support their recommendations were promptly posted on their website throughout the process.

The KHPA developed its recommendations within the context of three core principles which it utilized to guide its efforts. The three principles – 1) promoting personal responsibility, 2) promoting a medical home and prevention, and 3) providing and protecting affordable health insurance – represent a solid foundation upon which comprehensive health reform can be built in Kansas. As the health reform process moves forward in the coming years, these principles will be very helpful in framing the continuing debate and guiding policy changes.

It is important to recognize that the road to meaningful reform will take time, and a commitment to incremental change. While there are those who believe that health reform should be accomplished in one swift transformational change, experience has shown that fundamental change in large, complex systems such as this just take time. In addition, there is only so much that can be done to reform health care by individual states. There is much that states can do, but comprehensive reform will ultimately require the involvement of the federal government as well.

The KHPA has estimated that if all of its recommendations for expanding insurance and access to care were adopted, approximately 86,000 Kansans would be removed from the ranks of the uninsured. Whether or not that is achieved will depend on many factors, but the prospect of accomplishing this without having to enact a coverage mandate on individuals or employers is significant. If Kansas were to reduce its uninsured by anything close to that number, we would have made an important step towards the ultimate goal of assuring that all Kansans have access to health insurance.

As to SB 541, we support the key reform elements included in the legislation. In particular, we would like to comment on three of the five components of this bill. The first, found in New Section 4 of the bill, broadens the premium assistance program passed last year in SB 11. The premium assistance program is scheduled to begin next January, and then to gradually expand to cover low income families, up to 100% of the Federal Poverty Level. SB 541 would add childless adults up to 100% of FPL, effective in FY 2012. The expanded insurance coverage for low-income adults without children who earn up to 100% FPL, is a sensible extension of coverage to a population for which health insurance is currently unaffordable. Making insurance available to this population won't weaken private insurance markets or cause "crowding out" because these individuals are currently uninsured, and very unlikely to be insured without some assistance from the state.

The second provision in SB 541 we would like to comment on is found in New Section 5 of the bill, which creates a "Health Reform Fund" within the state treasury. Revenues from a proposed increase in the state tobacco tax would be deposited in the interest bearing fund, and the funds will be utilized solely to pay for health reforms. We strongly support earmarking all of the revenue from the tobacco tax for the benefit of health reforms, and in particular paying for expanded insurance coverage for uninsured Kansans.

Finally, we want to express support for the concept of incorporating the health care delivery model of the "medical home" into the various public programs administered by the KHPA, found at New Section 2 of the bill. The concept of the medical home was first identified and developed by the American Academy of Pediatrics about forty years ago. It has since been expanded and refined more recently (*Joint Principles of the Patient-Centered Medical Home*, February 2007) by several national medical specialty organizations which represent physicians in the primary care specialties (the American Academy of Family Physicians, American College of Physicians, American Academy of Pediatrics and American Osteopathic Association). The delivery model of the medical home has been identified as an important strategy to enhance the delivery of primary and preventive care, as well as improving comprehensive care coordination across the entire health care system. It is hoped that the medical home delivery model will promote cost effective care, and improve quality and health outcomes.

We would like to suggest a couple of amendments to this section of the bill, found on page 2, lines 13-39 of the bill. While the concept of a medical home most often implies an ongoing relationship with a primary care physician who provides, guides and

coordinates a patient's care, the model must be flexible enough to accommodate a variety of practice arrangements. For example, more and more physician practices (including primary care physician practices) deliver care through a team approach that involves nurse practitioners or physician assistants. Rural health centers are a good example of another such practice arrangement. Multi-specialty physician clinics are yet another example. While such care teams are physician-directed, both ARNPs and PAs may often serve as the primary point of contact for the patient, and fulfill an important part of the "medical home" role for the practice. We believe the definition of medical home should recognize that concept and approach, and our amendment attempts to do just that. Additionally, we have included a reference to the consensus document of the organizations cited above in subsection (d), as that document would be a very helpful reference tool when the KHPA and the stakeholders get together to develop the systems and standards for implementing the medical home in the state's public programs. Our suggested amendments with the strikeouts and additions is found below:

New Sec. 2. (a) As used in this section, ''medical home'' means a health care delivery *model in which a patient establishes an ongoing relationship with a physician or other personal care provider in a physician-directed team, to provide comprehensive, accessible and continuous evidence-based primary and preventive care, and to coordinate the patient's health care needs across the health care system in order to improve quality and health outcomes in a cost effective manner.* ~~*system that is person centered and family centered, providing accessible and continuous evidence-based, comprehensive, preventive and coordinated health care guided by a personal primary care provider who coordinates and facilitates preventive and primary care to improve health outcomes in an efficient and cost effective manner.*~~

(b) The Kansas health policy authority established under K.S.A. 2007 Supp. 75-7401, and amendments thereto, shall incorporate the use of the medical home delivery ~~*system*~~ *model within (1) The Kansas program of medical assistance established in accordance with title XIX of the federal social security act, 42 U.S.C. 1396 et. seq., and amendments thereto;*

(2) the health benefits program for children established under K.S.A. 38-2001 et seq., and amendments thereto, and developed and submitted in accordance with federal guidelines established under title XXI of the federal social security act, section 4901 of public law 105-33, 42 U.S.C. 1397aa et seq., and amendments thereto; and (3) the state mediKan program.

(c) The Kansas state employees health care commission established under K.S.A. 75-6502, and amendments thereto, shall incorporate the use of a medical home delivery ~~*system*~~ *model within the state health care benefits program as provided in K.S.A 75-6501 through 75-6523, and amendments thereto.*

(d) On or before February 1, 2009, the Kansas health policy authority in conjunction with the department of health and environment and state stakeholders shall develop systems and standards for the implementation and administration of a medical home in Kansas, consistent with the document "Joint Principles of the Patient-Centered Medical Home" (February 2007).

We look forward to working with the KHPA and the various stakeholder groups on the further development of the medical home concept, attributes and program details.

While not specifically a part of SB 541, there is much in the overall package of KHPA recommendations that deserves support. The recommendations around personal responsibility and improving healthy behaviors, and the informed use of health services through better transparency and improved health literacy, are all worthwhile efforts that deserve attention and discussion. The KHPA should be commended for recommending a ban on smoking in public places. The adverse health effects of tobacco are well-documented, and smoking cessation and educational efforts, particularly for adolescents, must be a part of any health reform plan. We also are supportive of expanded dental care for pregnant women, and expanded cancer screenings. The recommendations designed to help small businesses are also extremely important and worthy of continued study and discussion.

In short, the KHPA recommendations represent a solid start to meaningful health reform for the state of Kansas. As a result of the work of the KHPA, the legislature is now in a much better position to continue the reform process through informed, balanced policy choices. We appreciate the opportunity to comment on these recommendations, and look forward to working on health reform with the KHPA and the legislature in the coming months and years.

Testimony of the Kansas Health Consumer Coalition
Regarding SB 541: Medical home; small business grant program; establishing health reform fund; amending premium assistance
Presented to the Senate Health Care Strategies Committee
Submitted by Corrie Edwards
February 18, 2008

Thank you Chairperson Wagle for the opportunity to speak today in support of SB 541, relating to a medical home and premium assistance. My name is Corrie Edwards and I am the Executive Director of the Kansas Health Consumer Coalition (KHCC) based in Topeka.

The Mission of KHCC is to support state policies that will increases the availability of health care and health care insurance for all Kansans at affordable prices. SB 541 is the center piece of the Health Care Reform agenda proposed by the Kansas Health Policy Authority and warrants your support.

The Premium Assistance program authorized by the Kansas Legislature last year has been thoroughly studied and reviewed by the KHPA Board and staff and plans are underway to implement phase one of that program. Thousands of Kansas families will directly benefit from health coverage provided by this program. Funding phase one of the program is probably the most important step towards health care reform that you can take this year. It's essential. If you don't do anything else, do this.

Our second priority is the extension of the Premium Assistance program to cover childless adults beginning in 2011. Currently, Kansas provides no public health insurance to childless adults. The eligibility criteria for this extension are the same as the family program you have already enacted into law. To qualify for Premium Assistance a childless adult will have to be at 100% of Federal Poverty Level or less. For these Kansans, having health insurance will promote access to care and financial security.

Other parts of SB 541 are also important to Kansas consumers. Creating Medical Homes will be a great advancement in the quality of care and should also help control the overall cost of the state-funded health care programs. And the small business wellness grant program should be an effective tool to stimulate small business interest in programs to improve worker health. The benefits will be lower health care cost and higher worker productivity. Kansas will benefit from both.

Thank you for this opportunity to support passage of Senate Bill 541. The Kansas Health Consumer Coalition looks forward to building on our partnership with the Kansas Legislature to advance the concerns of Kansas consumers.

Respectfully submitted,

Corrie L. Edwards, MPA
Executive Director
Kansas Health Consumer Coalition
534 S. Kansas Avenue, Suite 335
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(785) 232-9997

Phil Mason will be unable to come to Topeka. In his place, Fr Matt Cobb from Wamego will present testimony for the Kansas Faith Alliance for Health Reform

Rev Matthew Cobb
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KANSAS FAITH ALLIANCE FOR HEALTH REFORM

Testimony on

Senate Bill No. 541

to the

Senate Committee on Health Care Strategies

Presented by

Fr. Matthew Cobb

Kansas Faith Alliance for Health Reform

February 18, 2008

Chairperson Wagle and Members of the Committee, I am Fr Matthew Cobb, Rector of St Luke's Episcopal Church in Wamego. I also serve as Chaplain for Mercy Regional Health Center in Manhattan and the Chair of the Task Force on Health for the Episcopal Diocese of Kansas. I am here today, however, as a member of the Kansas Faith Alliance for Health Reform. People from many faith traditions established the Faith Alliance last summer. Our mission is to advocate collectively for a health care system guided by ethically acceptable policies. I am pleased to appear before you today to provide comments in support of Senate Bill 541.

The Faith Alliance has held meetings in Hutchinson, Emporia, Wichita and Salina for discussion of health reform issues to be addressed this legislative session. As a result, a 30 member steering committee for the Faith Alliance became incorporated and has now received grant funding and donations. Clergy, conference leadership, and lay persons from 15 faith groups are currently included with more being added.

From across the state, we now have over 100 members who share a vision of equitable access to health care for all people of Kansas. We recognize that national solutions may be the only way to assure unfettered access to care. Nevertheless, it is our desire to help build and sustain consensus about the proper role of State government in ensuring equitable access and financing of health care. With this in mind, the Alliance adopted a position supporting the entire 21-point package of recommendations from the Kansas Health Policy Authority as practical first steps toward state health reform.

We selected three top priorities for our first year. We support all proposals related to tobacco use prevention and control including the tax on tobacco products. We urge not only aggressive marketing of HealthWave, the State Children's Health Insurance Program, but also an expansion of this program for children in families with incomes up to 250% of the federal poverty level. Finally, we support the expansion of health insurance coverage for young adults, employees of small businesses and any adults whose household incomes are at or below 100% of the poverty guidelines.

We are pleased that this bill and others were introduced on behalf of the Kansas Health Policy Authority to discuss and implement these recommendations. Additionally, we urge these proposals be considered as a set of strategies that should be adopted in full.

From our varied faith traditions, we all believe that society has both a moral obligation and an economic imperative to finance the care of its poorest members. Society does this through the work of many over-lapping public and private groups. We know that the solution is not and should not always be governmental. Faith initiatives in health promotion, charitable service, and sponsorship of hospitals and clinics are evidence of our tradition of compassion and action. However, we believe that governmental policy is required to assure that distribution of the cost of financing access to health care is equitable. When faith initiatives and forces within the health care marketplace are unable to provide adequate access to health care without excessive burdens, we believe that government action is essential.

We support the following provisions in SB541. We believe that impoverished adults should allowed health insurance coverage by inclusion in their children's HealthWave program. We support the establishment of a premium assistance plan to assist childless, low income adults with the purchase of private insurance or other benefits that are actuarially equivalent to the Kansas state employee health plan.

We also support new Section 5 that establishes a health reform fund in the state treasury to receive revenue obtained by the expansion of the tax on tobacco products.

We plan to remain involved with these issues as they move through the session. We will keep our members and their friends and colleagues informed about these Kansas health reform deliberations. Thank you for the opportunity to appear before this Committee. I will be happy to respond to any questions you might have.

Testimony in favor of Senate Bill 541
Senate Health Care Strategies Committee
February 18, 2008

Chairman Wagle and Committee members:

My name is Lisa Benlon, the Legislative/Government Relations Director for the American Cancer Society. We stand before you today in strong support of Senate Bill 541, as well as the other recommendations of the Kansas Health Policy Authority.

Senate Bill 541 establishes the important strategic framework for action by defining a Kansas "medical home" as a "health care delivery system that is person centered and family centered, providing accessible and continuous evidence-based, comprehensive, preventive and coordinated health care guided by a personal primary care provider who coordinates and facilitates preventive and primary care to improve health outcomes in an efficient and cost effective manner." This all inclusive definition could not be better stated.

Senate Bill 541's "medical home" framework for action gives us the important tools we need to work at the front end to find health care solutions. The last minute expensive emergency room option not only costs the patient, but us as Kansas taxpayers and other Kansans who pay higher health insurance premiums to help cover the unreimbursed costs. The "medical home's" comprehensive approach is to provide health care in an accessible, continuous, and coordinated manner to maximize results. It targets prevention, not reaction to a disease in its last stages. This foundation of patient-centered care is respectful of and responsive to the individual patient's needs and values. Quality health care is also best provided when all of the necessary medical data is in one place and made readily accessible to the care givers. Expansion of the person-centered "medical home" requires a strong partnership and commitment between mid-level practitioners and safety net clinics. This partnership is critical to best serve the needs of our rural communities and underserved areas of Kansas.

The American Cancer Society recently underwrote a significant national public awareness campaign related to the problem people have finding quality cancer care. Many uninsured and underinsured often do not realize their problem until they are confronted with a serious cancer diagnosis. "Medical homes" help to manage these chronic conditions and reduce spending on emergency rooms.

The American Cancer Society encourages the Health Care Strategies Committee to vote out Senate Bill 541 favorable for passage.

KAMU

Kansas Association
for the
Medically Underserved
The State Primary Care Association

1129 S Kansas Ave., Suite B Topeka, KS 66612 785-233-8483 Fax 785-233-8403 www.kspca.org

Senate Bill 541
Senate Health Care Strategies Committee
February 18, 2008

Cathy Harding
Executive Director
Kansas Association for the Medically Underserved

Madam Chairperson, members of the Committee, thank you for the opportunity to offer comments in support of SB 541. I am Cathy Harding, Executive Director of the Kansas Association for the Medically Underserved, also known by the acronym KAMU. KAMU's membership is comprised of 33 organizational and six associate members, all of which provide health services to low-income individuals regardless of ability to pay.

KAMU supports all of the components of this bill, but is most supportive of the medical home concept. This Bill defines medical home as "a health care delivery system…" that is "guided by a personal primary care provider." The focus of this definition on the system of care rather than on the specific type of practice or provider is exactly right. It allows for flexible systems of care that can be designed to best meet the needs of all Kansans in their own communities, including our most vulnerable citizens who are challenged to access needed health care services. It allows for comprehensive, effective and efficient approaches to be designed through solid collaborative efforts so that a real patient and family focus results.

Our member clinics see first-hand the poor patient outcomes that result from episodic care that results from patients' lack of financial resources. One of our clinics – the Community Health Center of Southeast Kansas (CHC/SEK) – reported to me just last week that they had two new patients present for care within a two week period of time that are seriously ill. One had not accessed care before at all; the other had simply used local emergency rooms and other urgent and episodic care facilities when symptoms persisted. The first of these patients was diagnosed by CHC/SEK with metastatic cancer, the second with advanced heart disease. The heart disease patient had presented various places with swollen feet and other symptoms only to be given various pharmaceuticals to address the immediate problem. She is now on a waiting list for a heart transplant.

Many of the safety net clinics provide truly comprehensive care that includes medical, oral and behavioral health care services. In fact, about half of our members provide in-house dental services. The ability to receive all of these services at one location is critical for the working poor and uninsured, who are further stressed to find the time or transportation to access these services. For these individuals and families, scheduling and managing multiple appointments at numerous locations while juggling work and children is extremely difficult. For many, a full service clinic is the best 'medical home' they can have.

People who have a medical home, a place to go for care where they are personally known as well as knowledge of their family and personal health histories, receive better care. The definition of medical home in this bill is a good start toward improving the health of all Kansans, and we encourage its adoption.

Thank you for your time and attention. I will stand for questions.

Senate Health Care Strategies
Committee
Date: February 18, 2008
Attachment 10

Thomas L. Bell
President

February 18, 2008

TO: Senate Health Care Strategies Committee

FROM: Chad Austin
Vice President, Government Relations

RE: SB 541

The Kansas Hospital Association appreciates the opportunity to provide comments in support of Senate Bill 541. This legislation consists of health reform provisions that have been recommended by the Kansas Health Policy Authority.

The Kansas Hospital Association supports the KHPA's three main goals: promoting personal responsibility, promoting medical homes and paying for prevention, and providing and protecting affordable health insurance. These goals provide a basis for broad health reform in Kansas and are consistent with KHA's *Principles of Health Reform* adopted by the KHA Board in June of 2007.

KHA believes that providing affordable and accessible health insurance to all is a critical piece of health reform. The KHPA proposals for aggressive enrollment of children currently eligible for Medicaid and HealthWave and expansion of Premium Assistance for adults up to 100% FPL are a good first step in achieving coverage for Kansans. Senate Bill 541 also establishes within the Kansas Health Policy Authority a small business wellness grant program that would assist small businesses in establishing wellness programs for their employees. Promoting personal responsibility and healthy lifestyles may have the greatest impact of any of the proposed health reform recommendations. Finally, engaging health care providers and promoting a patient centered medical home will significantly contribute to improved health outcomes as well as higher quality health care.

The Kansas Hospital Association believes Senate Bill 541 is a good start that begins to address several needed health reform changes. Thank you for your consideration of our comments.

Senate Health Care Strategies
Committee
Date: February 18, 2008
Attachment 11

Kansas Hospital Association
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Senate Committee on Health Care Strategies

February 18, 2008

Topeka, Kansas

SB 541 - Kansas Health Policy Authority Small Business Wellness Grant Program.

Chair Wagle and members of the Senate Health Care Strategies Committee, thank you for the opportunity to comment today in support of a portion of SB 541 providing for a small business wellness grant program. I am Leslie Kaufman and I serve the Kansas Cooperative Council as Executive Director. The Kansas Cooperative Council is a voluntary trade association representing all forms of cooperative businesses across the state, including agricultural, utility, credit, financial and consumer cooperatives. Approximately half our membership falls into the ag cooperative sector.

Kansas agricultural co-ops are, traditionally, small employers. Cooperatives have a history of looking out for their employees and one benefit they offer is insurance coverage for employees. In 1983, a group of farmer co-op managers worked with Kansas Farmers Service Association to form Agri-Business Benefit Group, Inc. (ABBGI), a 501 (c)(9) employee benefit trust, and the Agri-Business Benefit Plan under the Employee Retirement Income Security Act (ERISA). Since its inception, ABBGI has grown to provide a choice of three competitively priced medical plans and an optional dental plan to 73 Kansas farmers' cooperatives with over 1783 employee participants.

Many of our members belong to ABBGI. There is a strong interest within the group to look at options for implementing wellness programs for member co-ops and their participants. A small business grant program, such as the one envisioned by the Kansas Health Policy Authority and proposed in SB 541, could help facilitate initiating wellness programs within rural cooperatives.

As such, we would respectfully request your support for the creation of the small business wellness grant program. Thank you for your consideration. Should you have any questions regarding our testimony, please contact me at 785-220-4068. Thank you.

Leslie Kaufman, Executive Director
Kansas Cooperative Council

February 18, 2008

American Heart Association
Learn and Live
Midwest Affiliate
Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, South Dakota, Wisconsin and two counties in Kentucky

TO: Senate Committee on Health Care Strategies

FROM: Linda J. De Coursey, Senior Advocacy Director – Kansas
American Heart Association

RE: Written Testimony on SB 541 - Health Reform: Adding Commissioner of Education to KHPA Board; Medical Home Definition; Small Business Wellness Program; Expansion of Premium Assistance; Creating the Health Reform Fund.

Madam Chairwoman and members of the Senate Committee on Health Care Strategies:

Early in January of 2008, the American Heart Association wrote a letter of support for the Kansas Health Policy Authority's recommendations. The AHA believes that the 21 recommendations are critical first steps to transform the health care system and improve the health of Kansans.

It is the mission of the American Heart Association to build healthier lives free of cardiovascular disease and stroke. Since heart disease and stroke are the No. 1 and No. 3 killers of our Kansas citizens, our efforts to build healthier lives are arranged among eight public policy priorities: Obesity Prevention; Tobacco Control; Funding for Heart Disease and Stroke Research & Prevention; Stroke; Quality and Availability of Care; Chain of Survival and Women and Heart Disease. In one way or another, these issues are addressed in the 21 health reform recommendations delivered by the Kansas Health Policy Authority (KHPA) board in November of 2007.

The KHPA Board understands the importance of promoting healthy behaviors at an early age and the addition of the Commission of Education will provide a source of knowledge for the implementation of any school programs. Obesity is a major modifiable risk factor for cardiovascular diseases. The Advocacy efforts of the American Heart Association focus on promoting quality physical and health education, increased physical activity opportunities, strong nutrition policies and research to effectively treat and prevent obesity, especially in children. We hope to address this growing epidemic by focusing on policy and environment changes in the healthcare environment, communities, and schools.

Another major focus of the American Heart Association's advocacy efforts is to ensure that all U.S. residents have access to and coverage for appropriate and affordable quality care. The Association supports several principles: All U.S. residents should have prompt access to

appropriate and affordable quality medical care. Any proposal to improve access should include enhanced support and coverage for preventive care, appropriate emergency care, diagnostic procedures, risk modification programs and heart and stroke rehabilitative services. The Association should participate in developing cardiovascular disease and stroke guidelines for appropriate patient care and support increased research into methods to measure quality, outcomes, and cost-effectiveness. The AHA will pursue public policy solutions to encourage hospitals to implement the quality measures monitored by the AHA's quality improvement initiatives and consider legislation and regulatory efforts to improve patient safety. The AHA supports the adoption of evolving health information technologies that translate science into evidence-based practice. AHA acknowledges that Health IT has the capacity to improve patient outcomes and patient care.

The American Heart Association supports and endorses the 21 recommendations of the Kansas Health Policy Authority. We embrace the overarching goals of health reform of promoting personal responsibility; promoting medical homes; paying for prevention; and providing and protecting affordable health insurance.

It is American Heart Association's belief that the 21 recommendations are critical first steps to transform the health care system and improve the health of Kansans.

We would ask you to consider SB 541 favorably for passage. Thank you.

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Tobacco Free Kansas Coalition, Inc.

February 18, 2008
Testimony for
the Senate Health Care Strategies Committee
in Support of SB 541

Senator Wagle and Members of the Committee,

I am Mary Jayne Hellebust, director of the Tobacco Free Kansas Coalition, composed of voluntary and health professional organizations and individuals as well as state and local health agencies and wellness and tobacco prevention coalitions across the state. The coalition's mission is to reduce the economic and physical toll tobacco use causes in Kansas.

We come as one of many organizations supporting the 21 recommendations proposed by the Kansas Health Policy Authority (KHPA) to reform health practices in Kansas and to improve the health of all Kansans.

SB 541 provides for the process of establishing medical homes, the creation of a small business wellness program, and the expansion of premium assistance for health coverage for low-income Kansans, starting with families. Adopting these endeavors will swing the health focus in Kansas to prevention rather than treatment of diseases, especially for many low-income Kansans engaging in unhealthy behaviors that lead to the development of chronic--and costly--diseases.

Each year direct costs for treating tobacco-related illnesses in Kansas are estimated to be $927 million, which includes $196 million in Medicaid charges. Thus KHPA is responding to this health crisis by recommending a tobacco tax increase as well as a statewide clean indoor air law as proven ways to reduce tobacco use, still the most preventable cause of death in Kansas. This new revenue from a cigarette and a tobacco products excise tax increase will provide the implementation funding for the components in SB 540 and SB 541 that need additional resources. Kansas will gain health programs and reforms, and at the same time the addiction of adults and youth to tobacco products and exposure to the toxins in secondhand smoke will be decreased.

Adoption of the KHPA recommendations contained in SB 541 will ensure that the state of Kansas follows through on its commitment to improving the health of all its people.

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February 18, 2008

S.B. 541 Kansas Health Policy Authority, Medical Home, Small Business Wellness Grant Program and Health Reform Fund

Written Testimony

Senator Wagle and members of the Senate Health Strategies Committee, the Kansas State Nurses Association (KSNA) supports the Kansas Health Policy Authority's 21 point plan for health promotion, prevention and insurance initiatives aimed at covering more Kansans with health insurance. Their proposed strategies have been deliberately discussed, researched and they have been discussed within the health care community through active participation on their Councils throughout the past year. We applaud their work and support the momentum they have created to make changes in our health care delivery and financing system for health care. Registered nurses often see clients who have not had timely or adequate access to healthcare services, and their health is compromised as a result. We are particularly pleased with their wellness campaign focus, including tobacco prevention strategies like clean indoor-air and higher tobacco product excise tax.

Adding the Commissioner of Education to the KHPA-Support

KSNA supports adding the Commissioner of Education as the eight ex-officio member of the KHPA. Education and prevention go hand in hand, and their representation is crucial to Kansas being successful in any prevention efforts in promoting health and promoting healthy lifestyles.

Medical Home Definition-Support the Broad Concept

Contained in this bill is the concept of a "medical home", referenced in many documents regarding the provision of comprehensive healthcare services to Kansans. The bill on *page 3, lines 13 - 18* defines medical home as a

> *"health care delivery system that is person centered and family centered, providing accessible and continuous evidenced-based, comprehensive, preventive and coordinated health care guided by a personal primary care provider who coordinated and facilitates preventive and primary care to improve health outcomes in an efficient and cost effective manner".*

KSNA supports the **inclusive nature** of this definition, it recognizes that there are institutions like "federally qualified health centers" and "rural health clinics (over 150 in Kansas)" that will be the medical home for many Kansans. The more than 1400 Nurse Practitioners and 60 Nurse Midwives (both are Advanced Registered Nurse Practitioners) throughout Kansas are a significant part of the "personal primary care providers" throughout Kansas and are recognized by the current language contained in the bill for medical home providers. This definition focuses on the system of care rather than on the specific type of practice or provider. We would not be supportive of a definition that eliminates Advanced Registered Nurse Practitioners from being included in the definition of what constitutes a medical home as we embark on health care reform.

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Testimony of Kansas Association of Health Underwriters
Presented by Tom Bryon, Sr., Legislative Affairs Committee Chair
Regarding Senate Bill 541: Concerning Powers and
Duties of the Kansas Health Policy Authority
Presented to Senate Health Care Strategies Committee
Monday, February 18, 2008

Thank you Senator Wagle for this opportunity to discuss with your Committee our concerns about Senate Bill 541, one of the Health Reform recommendations of the Kansas Health Policy Authority. I am Tom Bryon with Association Benefits Advisor, Inc., and Chair of the Kansas Association of Health Underwriters (KAHU) Legislative Affairs Committee.

Before commenting about the specifics of the bill, I'd like to commend the Health Policy Authority for their efforts. They've covered a lot of ground in the past 10 months and have produced an impressive Health Reform package. There are many parts of their plan that we support and others where we think they are not going far enough, and still others where we think they are headed in the wrong direction. This afternoon I will limit my comments to the provisions of Senate Bill 541.

KAHU has no objections to adding the Commissioner of Education to the KHPA Board, or creating a medical home for state-funded health programs. Increasing care coordination and improving health outcomes are shared goals of all Kansans.

Senate Health Care Strategies
Committee
Date: February 18, 2008
Attachment 12

Also, we urge the Legislature and Health Policy Authority to consider creating incentives for health care providers to make investments in automating their offices and patient records. Electronic records are more accurate and less expensive and will improve the efficiency of medical homes and all care providers.

We also have no objections to the Small Business Wellness Grant Program. Many larger employers have already created Wellness Programs and a few smaller employers have done so too. All health insurance companies already offer health promotion and wellness programs to their customers, and it is not clear to us how a state-run grant program will significantly expand those programs. There seems to be no shortage of information available about the need to exercise more, eat and smoke less and take better care of ourselves. If a state grant program for small businesses might encourage people to embrace healthier lifestyles it is worth giving it a try.

Our primary concerns about Senate Bill 541 are found in Section 4 authorizing and expanding the Premium Assistance program. Our association was not involved in the health care debate during the 2007 legislative session, but when we heard that Senate Bill 11 contained authority for a premium assistance program we were initially encouraged. Several states have used premium assistance programs as the foundation for their Medicaid Reform initiatives. Florida, Idaho, South Carolina and Oklahoma are just a few states that have used premium assistance programs to enhance benefits, control costs, and expand coverage.

The Florida Medicaid Reform program is particularly note worthy and we encourage you to study it closely before appropriating money to implement and expand program designed by the Health Policy Authority.

The major shortcoming of the current Kansas premium assistance program is that it merely funds another state run entitlement program instead of helping uninsured Kansans purchase health insurance in the competitive market place.

Consumers who participate in the KHPA program will have very limited health insurance options; but there are many options in the current open market place that a true premium assistance program could utilize.

Consumers who participate in the program will not be able to participate in their employer's health care plan, because the KHPA Premium Assistance program is available only for the state-run plan. And consumers who participate in the KHPA plan will end up costing Kansas taxpayers more to support than a plan that subsidizes the purchase of insurance in the marketplace.

The Florida Medicaid Reform program should be considered a model for Kansas. The program operates under a Section 1115 waiver from CMS and began as a two-county pilot in Broward and Duval Counties in fiscal year 2006-2007. Medicaid participants in Broward County have their choice among 15 different programs and participants in Duval County have 7 options. The programs are free to design their benefits to meet the needs of specific groups. For example, one program might be designed to provide the benefits most needed by the frail elderly while another might be intended for young adults or families.

One of the chief advantages of this program is that participants can enroll in programs designed to meet their specific needs. And this plan specialization allows the insurance companies to control their costs because they aren't trying to offer a plan that meets the needs of all Medicaid eligibles.

An added component of the program is the ability of the Medicaid participant who has a job to opt out of the Medicaid options completely and use the state

premium assistance to subsidize their contribution to their employer's health care plan. This is a great tool for transitioning people out of Medicaid and back into private health care coverage. That's assuming, of course, that you want to encourage the ongoing viability of the private health insurance market.

Every time we've mentioned the Florida Medicaid Reform program to the Health Policy Authority is has been quickly dismissed. We've been told it doesn't work and we've heard that it hasn't been used by many people. But the program has more than 136,000 enrollees in Broward County and more than 88,000 enrollees in Duval County at the end of its first year. Florida is so happy with the program they are expanding it to three additional counties this fiscal year.

More importantly, the program has bells and whistles the Kansas program doesn't have that should make it even more attractive to Kansas policy makers. The program has an Enhanced Benefit Program, a Low Income Pool, a sophisticated Grievance Process and Complaint Resolution Process, and is required to operate with budget neutrality compared to the traditional Medicaid program still in place in the other counties.

There are hundreds of pages of comprehensive reports about the Florida Medicaid Reform program that can be found at www.FloridaHealthFinder.gov including a comprehensive evaluation of the program at the end of its first year.

We've asked ourselves many times why the Health Policy Authority hasn't expressed any interest in the Florida Medicaid Reform model. As we understand Senate Bill 11 from last year, developing Medicaid Reform recommendations was one of the assignments given to the Authority, and the Florida Reform model has attracted national attention.

It reminds me of one day when I was a young kid fishing with my dad. We were catching crappie and it was fun, but I wanted to catch a bigger fish. After catching several little crappie I finally asked my dad why weren't we catching any big bass. My dad explained that we were in the shallow cove fishing for crappie and if we wanted to catch the big bass we had to move down by the dam. We were fishing in the wrong spot for big bass.

If Kansas wants a real premium assistance plan and a plan to reform Medicaid, maybe we should look in some new places.

I've attached some basic information about the Florida Medicaid Reform program that we encourage you to review, and please go to the website to learn more about this innovative program. It may not be perfect, but it offers many advantages over the program designed by the Authority.

We don't believe the current Kansas program should be funded and we certainly don't think it should be expanded. There are better, more efficient and effective ways to serve people who don't currently have health coverage. We encourage you to look for options that truly reform Medicaid, provide consumer choice and enhance the private insurance market, while at the same time controlling the future costs to the State.

Senator Wagle, thank you again for this opportunity to speak to your committee. The members of the Kansas Association of Health Underwriters want to be a resource to the legislature as you work through the many complex issues of health reform. Our national office is tracking health reform and Medicaid reform efforts across the country and can provide you with excellent resources as you work through these issues. I'm available to answer questions at your convenience.

Wichita Independent Business Association

THE VOICE OF INDEPENDENT BUSINESS

Senate Committee on Public Health and Welfare
February 18, 2008
Neutral testimony to Senate Bill 541
by Tim Witsman

Chairman Wagle and honorable committee members:

My name is Tim Witsman. I represent the Wichita Independent Business Association and the Kansas Independent Business Coalition. SB 541 addresses the concepts of a "medical home," phased in "premium assistance," and the encouragement of small business wellness programs. Thank you for this opportunity to present neutral testimony on SB 541.

WIBA concurs there is evidence that having a "medical home" improves the quality of care and decreases the cost of health care. Dr. Rick Kellerman, Chair of the Department of Family and Community Medicine at the University of Kansas School of Medicine – Wichita is concluding a term as Chair of the National Association of Primary care Physicians. Dr. Kellerman spoke to our Board last week and the evidence he presented was impressive. It clearly indicates there are improved outcomes and reduced costs through a primary care based health system.

However, there is a job to be done in educating consumers, physicians and insurance companies and a need to change our current culture of how medical care is delivered. We must also alter the manner in which we reimburse physicians to make the concept of a "medical home" work through a primary care based health system. There will be challenges and costs associated with the implementation of a medical home system, however, if the projections made are correct, the long-term savings will far outweigh the initial investments.

With that said, our interest and the value that we see in a "medical home" does not convince us that state government is the most qualified force to lead and control such an effort. I work with three local initiatives to improve health care in our region: The Health Care Roundtable; The Business Coalition on Health; and The Health Access Project. I believe these local initiatives are a far better starting place to begin the implementation and utilization of a medical home. It is better for business and medical practitioners to develop and implement the game plan of a "medical home" than for the State to mandate, create, and control.

This also holds true when you consider the concept of a premium assistance program currently being offered by the KHPA. I have long been an advocate of the importance of public health and unfortunately it is a concept rarely interjected in today's health care reform debate. However, just as the implementation of a medical home will be better implemented at the local level, the needs of those unable to afford health insurance will also be better served by their local communities in the form of a safety net clinic. Insurance is a complicated reimbursement system that even the most educated have difficulty maneuvering. Furthermore, it is burdened with a tremendous amount of administration and bureaucracy. Instead, we believe, the state government should

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b ting to investing in local safety net clinics to serve the needs of the uninsured and working poor. W
B se safety net clinics can serve and fill the need of public health at a fraction of the cost the proposed KHPA premium assistance program. The individuals receiving the care from a local community clinic will have access to a less complicated and bureaucratic system. Furthermore, safety net clinics can also serve as a "medical home" to those who do not have access to a primary care physician outside of the clinics. Again, if we charge local officials and agencies to address the needs of their community, won't the solutions be more in touch with what is truly needed.

The last issue set out in SB 541 is the concept of grants for small business wellness programs. WIBA recently polled our members on whether they would participate in a wellness program if assistance was provided through incentives and over 60% responded favorably. While we believe that wellness is a key concept to controlling the sky rocketing costs associated with health care, we question whether the small business owner will really take advantage of such programs if they are again administered at the state level. Instead, we would like to join the state in working to implement these programs at a local level where they can be customized to meet the circumstances of each community. WIBA is currently working with our insurance provider to incorporate wellness incentives into our insurance products and are looking into possible membership benefits that include wellness programs. We would welcome discussions with KHPA on how state incentives might help bring several of our members together to utilize a joint or shared wellness program through WIBA. The time and energy successful wellness programs require is just simply prohibitive for the small business owner. Efforts by the state can be better directed if they partner with organizations such as WIBA to achieve their wellness goals.

I would be happy to answer your questions.

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