Approved: 4/2/09
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman Jim Barnett at 1:30 p.m. on March 11, 2009, in Room 136-N of the Capitol.

All members were present except Senator Haley who was absent.

Committee staff present:
Nobuko Folmsbee, Office of the Revisor of Statutes
Doug Taylor, Office of the Revisor of Statutes
Kelly Navinsky-Wenzl, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Jan Lunn, Committee Assistant

Senator Barnett introduced his pages for the day, Talia Smith and Jacob Wright from Emporia.

Conferees attending:
Corrie Edwards, executive director, Kansas Consumer Health Coalition

Others attending:
See attached list:

Health Information Technology for Economic and Clinical Health (HITECH)
Senator Barnett distributed a draft of a Resolution relative to HITECH (Health Information Technology for Economic and Clinical Health) legislation (Attachment 1). Doug Taylor, office of the revisor of statutes office, reviewed the proposed Resolution with committee members attending.

Upon a motion by Senator Kelsey to favorably pass out the Resolution as presented and a second by Senator Schmidt; the motion carried.

Senator Barnett distributed a letter to Kathleen Sebelius, the nominee to the position of Federal Secretary of Health and Human Services, encouraging review, development, and timely adoption of standards/criteria related to the adoption and use of health information technology systems and a health information exchange. Senator Barnett circulated the letter accompanied by an approval sheet, which all committee members signed and thereby indicated his/her approval for sending the communication (Attachment 2).

Informational Hearing on Medical Debt
Senator Barnett announced discussion on the informational hearing from March 3, 2009, will continue, and he re-introduced Corrie Edwards to the committee. Ms. Edwards indicated that the plan is to engage Kansas Health Institute as a partner to study the issue of medical debt. It is hoped results from the study will be available by October 2009. The comprehensive study will include what other states have done, what Kansas can do to standardize processes, and examination of a cap on medical debt interest rates.

Senator Barnett called attention to written testimony form Suzanne Cleveland, Kansas Health Institute, which focused on problem definition and examination of potential solutions. (Attachment 3)

Senator Barnett indicated he would like the opportunity to meet with Dr. Eberhart-Phillips, and other people in the field of public health to consider a vision for exploring public health issues during the next several years. Committee members agreed and requested Senator Barnett proceed with the meetings.

SB 248 - Electronic logging system for sale of methamphetamine precursor
Senator Barnett requested that Ms.Folmsbee brief those attending on the balloon amendment that was crafted through collaboration and compromise by both opponents and proponents. The amendment included clarification on various sections of the legislation, creates a new subsection relative to waivers that the Board of Pharmacy can grant, funding for implementation and maintenance of an electronic logging system, and capabilities of state or private vendors selected for providing the technology. A new section was added related to promulgation of rules and regulations. Various technical amendments were also discussed.

Upon a motion by Senator Schmidt to move **SB 248** out favorably as amended with a second by Senator

Minutes of the Senate Public Health and Welfare Committee at 1:30 p.m. on March 11, 2009, in Room 136-N of the Capitol.

Kelsey, the motion passed.

SB 220 - Emergency medical services; authority of the board of emergency medical services.

Ms. Folmsbee discussed the amendments proposed that added certain definitions, replaced terms "mobile intensive care technician, "emergency medical technician-defibrillator," emergency medical technician-intermediate," and "first responder" with "attendant." In addition the term "medical adviser" was replaced with "medical director." Rules and regulations relative to quality assurance/improvement programs, and staffing levels for attendants were also added. Responsibilities and authorities delegated to the Board of Emergency Medical Services were included. In addition, the disposition of charges and fees for ordinary civil actions in district court were included. The legislation applies to ground ambulance services only.

Committee members discussed the legislation. Senator Barnett recognized Robert Waller, executive director of the Kansas Board of Medical Services; K. C. Jones, Kansas Chapter of the Association of Air Medical Services; and Mick McCallum, vice president of Kansas Air, who were in the audience and individually offered comments related to various sections of **SB 220** (there was no written testimony).

Senator Barnett closed the hearing on **SB 220** indicating that final action would occur at a subsequent meeting.

Chairman Barnett announced that an electronic document containing follow-up to Dr. Andy Allison's presentation, "Implementing Data-driven Policy through Medicaid Transformation had been sent to committee members. This document is attached as a matter for the permanent record (Attachment 4).

The meeting was adjourned at 2:22pm.

The next meeting is scheduled for March 16, 2009.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE GUEST LIST

DATE: March 11, 2009

NAME	REPRESENTING
Bob Williams	Ks. Assoc. Osteopathic Med.
Gary Robbins	Ks Optometric Assn
Colin Thomasset	ACMHCK
Keith Rickard	The Guidance Center
Krista Wright	Parent of a page
Tracy Russell	Ks. Health Consumer Coalition
Carrie Edwards	Ks. Health Consumer Coalition
Karen Braman	Preferred Health Systems/KHSPC
Jeff Ellis	KHSPC/Lathrop & Gage
Martie Ross	Lathrop & Gage LLP
Nancy Zogleman	Polsinelli
Laurel Jeffries	VHG
Bruce Witt	VCHS/PHS
Robert Walla	KSEMS
Scott C May	CMH Transport
Connie Hubbell	KFMC
Larry Pitman	KFMC
Debra Billingsley	KBOP
Cynthia Smith	SCL Health Systems
Chad Austin	KHA

Suzanne Cleveland	KCH
Chris Tilden	KDHE
Mike McCall	KanAMS
Neil Jones	KanAMS
Jeff Bloemker	Cerner
Marlee Carpenter	KAHD
HENRY SOHN	Appriss
Dodie Wellshear	KAFP
Patrick Vogelsang	Kennedy and Assoc.
Dustin Meyer	KHPA

SENATE RESOLUTION NO. _____

By

A RESOLUTION urging review, modification and reorganization of laws pertaining to the maintenance and availability of health information.

WHEREAS, Kansans have an interest in the confidentiality, security, integrity and availability of their health information; and

WHEREAS, The availability, quality and efficiency in the delivery of health care, including establishment of medical homes, depend upon the efficient and secure collection, use, maintenance and exchange of health information; and

WHEREAS, The use of current and emerging technology facilitates the efficient and secure collection, use, maintenance and exchange of health information; and

WHEREAS, Kansas' out-dated and decentralized statutory and regulatory scheme, as well as its interaction with federal mandates, creates confusion and is a significant barrier to the efficient and secure collection, use, maintenance and exchange of health information: Now, therefore,

Be it resolved by the Senate of the State of Kansas: That the laws of Kansas should be reviewed, modified as necessary and construed so as to protect the interests of individuals in the confidentiality, security, integrity and availability of their health information; promote the use of modern technology in the collection, use, maintenance and exchange of health information; promote uniformity in policy and codify all standards in a cohesive and comprehensive statutory structure; and

Be it further resolved: That the Secretary of the Senate is directed to provide an enrolled copy of this resolution to the E-Health Advisory Committee, Kansas Health Policy Authority.

Public Health and Welfare
Date: 03/11/09
Attachment: 1

STATE OF KANSAS

JIM BARNETT
SENATOR, 17TH DISTRICT
CHASE, COFFEY, GREENWOOD
LYON, MARION, MORRIS, AND OSAGE
COUNTIES

TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS
CHAIR: PUBLIC HEALTH AND WELFARE
CHAIR: KANSAS HEALTH POLICY OVERSIGHT COMMITTEE
MEMBER: AGRICULTURE
FINANCIAL INSTITUTIONS AND INSURANCE
ORGANIZATION, CALENDAR AND RULES

March 9, 2009

Governor Kathleen Sebelius
State Capitol Building
Topeka, KS

Dear Governor Sebelius:

As you know, one of the major provisions of the recently passed economic stimulus legislation provides funding to encourage the adoption and use of health information technology (HIT) systems and promote health information exchange. A large portion of this funding will establish temporary Medicare and Medicaid payment incentives for hospitals and physicians.

In general, to be eligible for the temporary Medicare and Medicaid payment incentives, hospitals and physicians must already have in place a "certified electronic health record (EHR) system" and be a "meaningful user" of such a system. This would include using a "certified EHR system" that can exchange heath information and report on quality measures. These criteria, where not completely defined in the legislation, would be established by the Secretary of the Department of Health and Human Services. The Secretary would be responsible for developing standards by FFY 2010 that will allow for secure nationwide electronic exchange of health information.

The purpose of this letter is to encourage the timely adoption of these standards and criteria. If the Department waits until the end of FFY 2010 for the adoption of such standards, we think the adoption process will be substantially slowed down. If providers are to be in a position to receive these incentive payments when they become available, the planning must start now. The faster the Department can develop and adopt the relevant standards and criteria, the faster the goals of this legislation will be met.

Thank you for your consideration of our comments. We stand ready to assist this process in any way possible.

Sincerely,

Senator Jim Barnett
Chairman, Public Health and Welfare Committee

Public Health and Welfare Committee Members:

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TOPEKA, KS 66612
785-296-7384

Public Health and Welfare
Date: 03/11/09
Attachment: 2

Senator Jim Barnett, Chairman, Public Health and Welfare

Senator Vicki Schmidt, Vice Chair, Public Health and Welfare

Senator David Haley, Ranking Minority Member, Public Health and Welfare

Committee Members:

Senator Pete Brungardt

Senator Laura Kelly

Senator Jeff Colyer

Senator Dick Kelsey

Senator Mary Pilcher-Cook

Senator David Wysong

KANSAS HEALTH INSTITUTE

For additional information contact:

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Website: www.khi.org

Senate Public Health and Welfare Committee

March 3, 2009

Medical Debt

Suzanne Cleveland, J.D., Senior Analyst
Health Care Finance and Organization
Kansas Health Institute

Information for policymakers. Health for Kansans.

The Kansas Health Institute is an independent, nonprofit health policy and research organization based in Topeka, Kansas. Established in 1995 with a multiyear grant from the Kansas Health Foundation, the Kansas Health Institute conducts research and policy analysis on issues that affect the health of Kansans.

Medical Debt

Defining the Problem
and Examining Potential Solutions

March 3, 2009

Suzanne Cleveland, J.D.
Senior Analyst
Kansas Health Institute

Causes of Medical Debt

- Medical debt is the result of multiple issues
  - Sheer cost of medical care (rising)
  - Increased cost-sharing
  - Shrinking coverage of services/medications
  - Lack of transparency/lack of awareness of cost and/or charity care options
  - Fear/lack of education about the possibility of negotiating with provider to reduce debt or develop payment plan
  - Insurance status

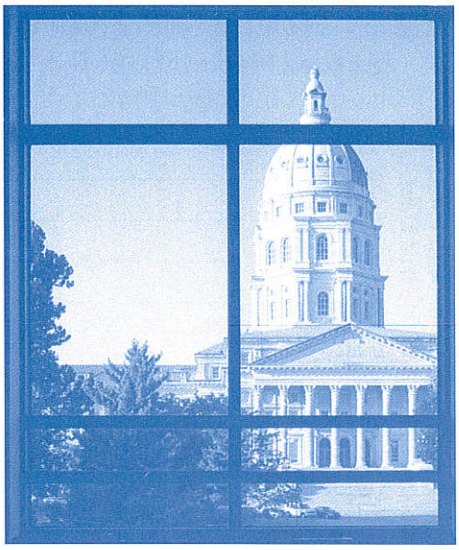
2-2

Looking Forward

- KHI's Underinsurance Project:
  - Recently held convening, gathered insight from various stakeholders
  - Further work will define and quantify underinsurance in Kansas
- KHI's Medical Debt Project
  - Will evaluate legal treatment of medical debt in other states and at the federal level
  - Will examine current and proposed policies and their potential utility in Kansas

2-5

KHI/09-01 • January 2009



Issue Brief

KANSAS HEALTH INSTITUTE

The Growing Health and Financial Costs of Inadequate Health Insurance

Barbara J. LaClair, M.H.A.
Gina C. Maree, M.S.W., LSCSW

More Information

This Issue Brief is the first in a series of reports that will be issued as a part of an initiative to better define underinsurance and determine the extent of the problem in Kansas.

This brief and the forthcoming reports will be available at www.khi.org.

Key Points

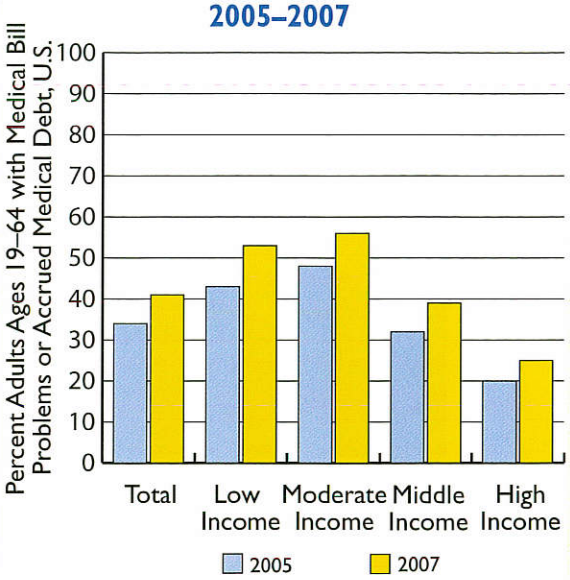
- Approximately 25 million individuals in the United States are underinsured and their numbers have increased significantly in recent years.
- Medical debt is the primary cause of approximately half of all bankruptcy filings in the U.S.
- In 2007, 41 percent of working-age adults in the U.S. had trouble paying their medical bills or had medical debts.
- From 2002–2006, approximately 500,000 adult Kansans, who were insured, did not seek needed medical care due to cost.
- Insured individuals with medical debt are three times more likely than those without debt to postpone or forgo needed care or cut back on prescription medications.
- Rural residents and other consumers who purchase health insurance in the individual and small group markets are more likely to be underinsured than those in larger group plans.

BACKGROUND

While much attention has been devoted to addressing Kansas' uninsured, far less has been focused on the underinsured. Because health insurance plans rarely cover all medical expenses, increasing numbers of insured adults are finding themselves unable to pay their share of the costs. Studies show that underinsured persons frequently postpone or forgo recommended health care or cut back on needed prescription medications because of costs. In addition, many incur substantial medical debt, which in extreme cases can force people into bankruptcy.

Many factors are contributing to the rise in health care expenses and medical debt. Most health insurance plans require varying levels of cost sharing through deductibles, co-pays, and coinsurance. And in recent years, those out-of-pocket spending requirements have been increasing in part because of efforts by policymakers and insurance carriers to manage costs and maintain

Figure 1. **Problems with Medical Bills or Accrued Medical Debt Increased, 2005–2007**



Notes: Income refers to annual income. Low income < $20,000; moderate income is $20,000 – $39,999; middle income is $40,000 – $59,999; and high income is $60,000 or more.

Source: Collins, S. R., Kriss, J. L., Doty, M. M., & Rustgi, S. D. (2008). *Losing Ground: How the loss of adequate health insurance is burdening working families.* New York, NY: Commonwealth Fund.

affordable premiums. In addition, plans may impose annual or lifetime payment caps, and may exclude or limit coverage for specific illnesses or treatments. Coverage exclusions due to waiting periods or pre-existing conditions may also result in out-of-pocket expenses.

A SERIOUS PROBLEM, WITH SERIOUS CONSEQUENCES

Although there is a lack of consensus on how to define and measure the prevalence of the underinsured, sufficient evidence exists to conclude that the scope of the problem in the U.S. is substantial. A recent report by the Commonwealth Fund estimated that 25 million adults were underinsured in 2007, up from 16 million in 2003. In the same study, 41 percent of working-age adults reported problems paying their medical bills or said that they had medical debt (Figure 1). Sixty-one percent of those with medical debt said they were insured when the debt was incurred. In the past five years, studies have shown an increase in the underinsured rate and significant declines in the adequacy of coverage for middle-class, working families. Additional research found that rural residents and other consumers who purchase health insurance in the individual and small group markets are more likely to be underinsured than those in larger group plans.

In general, medical debt is a problem for middle-class families. A sizable majority of privately-insured adults with medical debt — 78 percent — hold full-time jobs. One study found that these individuals were three times more likely to skip recommended tests or treatments due to costs, twice as likely to not fill prescriptions and four times more likely to postpone care than privately insured individuals without medical debt.

Medical debt also contributes to credit card debt, home forfeiture and reduced access to credit. Two-thirds of families who reported problems paying medical bills also struggled to afford other necessities, such as housing, transportation and food. A recent study of bankruptcies in the U.S. found that approximately half could be traced back to serious medical problems resulting in medical debt. In some cases, underinsured individuals do not have access to the same safety net of their uninsured counterparts because having insurance — adequate or not — disqualifies them from free care.

SCOPE OF THE PROBLEM IN KANSAS DIFFICULT TO MEASURE

Although the number of underinsured Kansans cannot be quantified due to limited state-specific data, there are indications that inadequate coverage is a problem for many in the state. In surveys conducted from 2002–2006, more than half a million insured Kansans said they did not seek needed medical care due to cost. A 2006 study conducted by The Access Project and Brandeis University surveyed more than 1,000 patients at Kansas community health centers regarding their families' insurance status and medical debt. This study found that medical debt was a problem for insured families, even when everyone in the family was covered. Not only did more than half of the families report having medical debt, 48 percent said they had delayed medical care because of it (Figure 2) and 52 percent said it had made paying for housing difficult. Many also said they had been forced to borrow money to pay their bills.

The same research organizations also conducted a survey of almost 300 Kansas farm families in 2005 and found that although 95 percent were insured, 17 percent reported having medical debt. This percent is even higher — 29 percent — when the families are non-elderly.

The University of Kansas conducted a small study in 2005 to gain a more personal understanding of the consequences of being underinsured. Researchers interviewed a sample of fifteen underinsured Kansans. Some said they had exhausted lifetime savings to pay medical bills. Others said they had lost homes or had been forced to file bankruptcy. Also, many of those interviewed said both they and family members had delayed or gone without recommended medical care or cut back on their prescription medications because of cost concerns. Some also reported that they had difficulty qualifying for credit and paying for housing. For these Kansans and many others like them, having health insurance was not sufficient to protect them from unaffordable health care expenses.

THE CHALLENGE OF DEFINING AND MEASURING THE UNDERINSURED

One of the biggest challenges to understanding the prevalence of the underinsured is the lack of agreement on a definition and approach to measurement. Although defining and measuring the underinsured is challenging, many agree that out-of-pocket medical expenses and adequacy of health insurance benefits are important factors to consider. To date, researchers have taken various approaches:

Medical Expenses

One frequently-used approach is to count as underinsured those individuals who were insured for the full year, but reported at least one of the following:

1) Out-of-pocket medical expenses equal to 10 percent or more of household income,

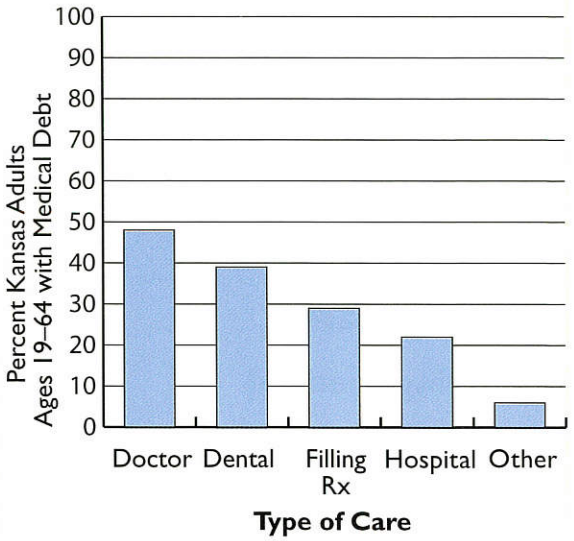
2) Out-of-pocket medical expenses equal to or greater than 5 percent of income if the household income is below 200 percent of the Federal Poverty Level, or

3) Health plan deductibles equal to or exceeding 5 percent of the household income.

Some studies have assessed an individual's risk for spending a defined percent of annual income on health care, while others count the numbers of insured patients who report delaying or not getting recommended health care due to cost concerns.

These approaches have limits because there is little consensus on what level of out-of-pocket medical expense is both adequate and reasonable. Measurement of expenditures incurred for health care services is likely to underestimate rates of underinsurance, because it fails to capture "non-users" of health care services. Non-users may have good health and not yet need medical care, or may have postponed or not sought care due to cost concerns. Within this array of approaches, further variations exist, such as whether insurance premium costs are included in the total expenditure tally and whether Medicare-aged adults should be considered.

Figure 2. **Care Delayed Because of Medical Debt, Kansas**



Note: Among respondents with medical debt. Multiple responses possible.

Source: Pryor, C. & Prottas, J. (2006). *Playing by the Rules but Losing: How medical debt threatens Kansans' healthcare access and financial security.* Boston, MA: The Access Project.

Adequacy of Health Insurance Benefits

Some studies define and measure the underinsured based on the adequacy of their health insurance coverage compared to a pre-established set of benchmark benefits. Others measure the individual's perception of the adequacy of his/her health insurance benefits.

Attempts to define and measure the underinsured by assessing the adequacy of a benefit package is complicated by the lack of consensus on a standard minimum benefits package and on what constitutes "adequate" coverage. Using consumer surveys to measure the adequacy of insurance coverage is problematic because consumers often do not know whether their plan is sufficient

Studies indicate that the number of underinsured in the U.S. is growing and that increasing numbers of insured families are incurring medical debt.

KANSAS HEALTH INSTITUTE

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KHI/09-01 • January 2009

until they have an acute or chronic health problem.

As illustrated above, there is not a perfect approach to defining and measuring the underinsured. This lack of agreement in an approach can result in policy discussions being derailed by debate over the definition and measurement of the underinsured. Therefore, both a common definition of the problem and means of measuring it are needed to ensure that policy discussions remain focused on the challenges faced by the underinsured and the policy options for addressing them.

POLICY IMPLICATIONS

Studies indicate that the number of underinsured in the U.S. is growing and that increasing numbers of insured families are incurring medical debt. Studies also confirm that people don't seek or receive needed health care when they are underinsured and concerned about medical debt. Although the scope of the underinsurance problem in Kansas is unknown, it is clear that many insured Kansans are postponing or foregoing recommended care because of cost. In addition, high health care costs and medical debt are causing financial problems for some Kansans, up to and including bankruptcy.

As policymakers seek to address the increasingly urgent issues of rising health care costs and growing numbers of uninsured, they may be tempted to focus on options that attempt to make insurance premiums more affordable by increasing out-of-pocket expenses and reducing the number of required benefits. Policy options like high-deductable plans, increasing minimum co-pays, and reducing benefit mandates for small businesses and young adults might help to reduce health care expenditures and the number of uninsured, but they could also increase the number of people with inadequate insurance — the underinsured. These people, including many Kansans, could find themselves paying for insurance they can't afford to use. As policymakers face challenging health policy decisions, they should carefully consider the adequacy of proposed insurance options and the potential unintended consequences of shifting costs to consumers.

Acknowledgments

Funding for this project was provided by:

- The Health Care Foundation of Greater Kansas City — Providing leadership, advocacy and resources that eliminate barriers to quality health for the uninsured and underserved in our service area.
- The Kansas Health Foundation — A private philanthropy dedicated to improving the health of all Kansans. For more information about the Kansas Health Foundation, visit www.kansashealth.org.
- The REACH Healthcare Foundation — A nonprofit charitable organization dedicated to improving access to quality health care for poor and medically underserved people.
- The Sunflower Foundation: Health Care for Kansans — A Topeka-based philanthropic organization with the mission to serve as a catalyst for improving the health of Kansans.
- The United Methodist Health Ministry Fund — A foundation based in Hutchinson with the following mission: "Healthy Kansans through cooperative and strategic philanthropy guided by Christian principles."
- The Wyandotte Health Foundation — A private charitable organization located in Kansas City, Kansas, that has this mission: "To promote and improve the health of Wyandotte County citizens, particularly the indigent, through grants and collaborative efforts."

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Chairman Barnett

Senate Public Health and Welfare Committee Meeting

February 24, 2009

Agency Response to Follow Up Questions
March 10, 2009

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State Employee Health Plan:
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Fax: 785-368-7180

State Self Insurance Fund:
Phone: 785-296-2364

Public Health and Welfare
Date: 03/11/09
Attachment: 4

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Request from the Senate Public Health and Welfare Committee:
Agency response to 2.24.09 hearing questions

1. Are pharmacy claims paid by managed care organizations (MCO) included in breakdown of Medicaid spending for pharmacy in the testimony: where is the reflection of the MCO expenditures?

    - No, the MCO's are not included in the breakdown of Medicaid spending for pharmacy in the testimony distributed. The testimony only looked at the fee-for-service component, which the estimated pharmaceuticals purchased proportion is $160 million. The reflection of the MCO expenditures is included in the capitation payments administered to the MCO's. Capitation payments are payments that the KHPA makes to the MCO's to account for the care that they administer to the members. Payment per member per month is determined by a variety of factors including, age, sex, and location.

2. When a MCO has an inadequate provider network and a beneficiary has to be sent to an out-of-network provider, is transportation is provided? Additionally, who pays for the transportation to and from the provider if the beneficiary is sent to an out-of-network provider?

    - Yes, transportation is provided to the beneficiary, even if they are sent to an out-of-network provider. Furthermore, the MCO is obligated to pay for the transportation to and from the provider if the beneficiary must be sent to an out-of-network provider.

3. What might be the available resources for the HIE and HIT money included in ARRA?

    - Please see the attached American Recovery and Reinvestment Act (ARRA) Health-Related Provisions Fact Sheet, and the Title XIII Summary Sheet.

4. Please provide a description of the structure of look-alike FQHC clinics and how they fit into the 2009 transformation process.

    - Look-alike FQHCs meet all of the requirements for FQHC status; however they do not receive an annual Federal 330 grant, whereas FQHCs qualify for Federal 330 grant money, look-alikes do not. Look-alike clinics may gain look-a-like status at any time during the year, as FQHCs may

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Fax: 785-296-6995

only gain their status annually during the grant process. Look-alike clinics and FQHCs are treated the same by Medicaid. They receive enhanced (cost based) interim reimbursement, wrap-a-round payments, and annual cost based settlement.

- The 2009 Medicaid program review will encompass a review of the FQHC look-alike clinic (Kansas has only one), it will be assessed in the same manner as FQHCs. Please see the attached draft analytic plan developed with KHPA and KDHE staff members.

5. What kinds of programs will come under implemented HIT infrastructure money provided in the ARRA?

   - Please see the attached American Recovery and Reinvestment Act (ARRA) Health-Related Provisions Fact Sheet, and the Title XIII Summary Sheet.

- Overview of Federally Qualified Health Centers (FQHCs)
  - Description and purpose of FQHCs
    - Federally Qualified Health Centers (FQHC), also known as community health centers, are federally designated providers that receive direct federal funding and enhanced reimbursement rates for public insurance to assist in their delivery of medical care to uninsured and other underserved populations. There are currently eleven Kansas-based FQHCs and one FQHC look-alike. There are also two Missouri-based FQHCs with sites in Kansas.
  - History
    - The federal community health center program began in 1962 with passage of the Migrant Health Act, funding services for migrant and seasonal farm workers and their families. In 1964, the broader community health center program began with the Economic Opportunity Act. In the 1970s, Congress permanently authorized health centers as "community health centers" and "migrant health centers" under sections 329 and 330 of the Public Health Service Act. In 1987, the Health Care for the Homeless Program was created, and the Public Housing Primary Care Program was established in 1990. In 1996, all four programs (community, migrant, homeless, and public housing) were brought under section 330 of the Public Health Service Act.

      In 2001, President Bush proposed a significant expansion of the health center system. The goal of initiative was 1200 new or expanded community health centers. To meet this goal, federal funding for the program nearly doubled, from slightly more than one billion dollars to more than two billion presently. During this period, five new FQHCs were funded in Kansas. An additional received expanded funding during this period.

  - Definitions
    - <u>Safety Net Clinic</u>
      - The term safety net clinic is often used to describe clinics that either through mission or usage serve a high number of uninsured or other underserved populations.
        - The Institute of Medicine in its 2000 report on "America's Health Care Safety Net," defined a core safety net provider as having two characteristics:
          1. "either by legal mandate or explicitly adopted mission, they offer care to patients regardless of their ability to pay for those services; and
          2. a substantial share of their parent mix are uninsured, Medicaid, and other vulnerable patients."
  - Stakeholders Roles and Responsibilities

- KHPA
- KDHE (PCO)
    - The Primary Care Office (PCO) in the Kansas Department of Health and Environment receives federal funding to represent the needs of underserved populations and the health professionals who serve them. The assessment and assistance work of the PCO is focused on helping local communities through health care access planning, data assistance, specific program services, and technical consultation. The Kansas PCO also manages the state program of support to clinics, including FQHCs, that serve uninsured and other underserved populations.

- KAMU (PCA)
    - The Kansas Association for the Medically Underserved (KAMU) is the federally-funded primary care association (PCA) for the state of Kansas. PCAs receive federal funding to provide support and technical assistance to FQHCs and to assist communities interested in applying for federal 330 funding. KAMU includes both FQHCs and other clinics that serve the underserved in its membership.

  - Recent Changes for FQHCs
    - Place of Service changes to improve wrap around payment process
  - National Issues for FQHCs

- <u>Proposed rule on designation of Medically Underserved Areas and Health Professional Shortage Areas</u>

  On February 29, 2008, the U.S. Department of Health and Human Services published the notice of a new, combined federal method, the Index of Primary Care Underservice, to replace the current federal designations of Medically Underserved Areas (MUA), Medically Underserved Populations (MUP), and Health Professional Shortage Areas (HPSA). FQHCs currently must be sited in an MUA or MUP.

  The new method is intended to be a better measure of access to health care using nine community characteristics that increase need or risk, including population below 200 percent of the federal poverty level, unemployment rate, percent of the population 65 and older, population per square mile, percent of the population nonwhite, percent of the population Hispanic, age-adjusted death rate, and low birth-weight or infant mortality rates The method includes, along with the currently collected practice data for physicians, practice data for physicians assistants, advanced registered nurse practitioners, certified nurse midwives, and medical residents. The method calculates primary care provider demand by establishing a barrier-free population-to-provider ratio based on physician practice characteristics and age and gender of the population.

Following a twice-extended comment period, HRSA plans to make changes in the proposed rule. A new Notice of Proposed Rulemaking will be issued for further review and public comment prior to the U.S. Department of Health and Human Services issuing a final rule.

- Proposed Centers for Medicare and Medicaid Services Proposed Rule on changes in payment provisions for Federally Qualified Health Centers
  On June 26, 2008, the Center for Medicare and Medicaid Services issued a proposed rule that includes updated payment provisions for FQHCs. The rule would revise the FQHC payment methodology to set Medicare payment at 80 percent of reasonable costs, after the application of deductibles. Beneficiary deductibles and coinsurance charges would be deducted from approved reasonable costs, and FQHCs would be paid the balance up to the payment limit. Total payments for Medicare services could not exceed the approved reasonable cost amount.

- Status of Funding and Likelihood of further expansion
  The federal stimulus package contains $1.5 billion for FQHC infrastructure expenditures, including construction, renovation, equipment, and the acquisition of health IT systems. It also contains $500 million for health center operations, including new sites, increased services and supplemental payments to existing centers to accommodate a spike in uninsured patients.

- Federal Grants
  - Description of federal grants
  - **Figure 1** – Total FQHC grant funding per SFY (2004 – 2007) *KHDE data
  - **Figure 2** – Total FQHC grant funding by grant per SFY (2004-2007) *KHDE data
  - **Figure 3** – FQHC Revenue – SFY 2007 *UDS data
  - Types of Grants
    - Federal 330 funding
    - State Primary Care
      - Describe what a primary care grant can and cannot finance
      - **Figure 4 –** total primary care grant funding for FQHCs per SFY (2004 – 2007) *KDHE data
    - State Dental Assistance
      - Describe what a dental assistance grant can and cannot finance
      - Funding did not begin until SFY 2008 (not w/in report dates)
    - Foundation Dental Hub Assistance
      - Describe what a foundation dental hub assistance grant can and cannot finance
      - Funding did not begin until SFY 2008 (not w/in report dates)
    - Prescription Assistance
      - Describe what a prescription assistance grant can and cannot finance
      - **Figure 5 –** for total prescription assistance grant money for FQHCs per SFY (2004 – 2007) *KDHE data

- Types of FQHC facilities
  - **Figure 6** – types of FQHC facilities – SFY 2007 *MMIS data
  - Types of FQHC facilities
    - FQHCs
      - To be designated a Federally Qualified Health Center, a clinic must be located in a federally designed medically underserved area (MUA) or serve a medically underserved population (MUP). FQHCs must be non-profit or public entities, that provide comprehensive primary care services, referrals, and other services needed to facilitate access to care, such as cases management, translation, and transportation. FQHCs must provide this care to anyone in their designed service area regardless of the patient's ability to pay for their care, using a sliding fee scale. They must have a governing board made up of at least 51 percent patients of the clinics. FQHCs receive federal 330 funding and cost-based Medicare and Medicaid payment to assist with the cost of providing services in their community.
        The Centers for Medicare and Medicaid Services is responsible for administering FQHC payment policy. The Health Resources and Services Administration, though, determines eligibility for designation.
      - **Figure 7** – FQHC expenditures per SFY (2004 – 2007) *MMIS data
      - **Figure 8** – Total Expenditures by beneficiary population per SFY (2004 – 2007) *MMIS data
    - Look-a-Like FQHCs
      - Clinics that meet all of the requirements for FQHC status may apply to receive designation as an FQHC look-alike. The benefit of this status is enhanced reimbursement for Medicare and Medicaid services. FQHC Look-alikes do not receive an annual 330 grant.
    - Community-Based Primary Care Clinics
      - For SFY 1992, the Kansas legislature appropriated state funding for community-based projects that serve uninsured and other underserved populations. These clinics must be public or not-for-profit entities, provide primary medical or dental care services, be set up as a source of on-going care for their patients, and provide care regardless of a patient's ability to pay using a sliding scale with charges based on income. For SFY 2008, there are 36 state-funded clinics, with twelve FQHCs and one FQHC look-alike.
    - Rural Health Clinics
      - Rural health clinics also receive cost-based reimbursement from Medicare and Medicaid. The designation was created in 1977 to assist clinics in rural areas federally designated as underserved. Rural health

clinics must use nurse practitioners or physician assistants to provide the majority of medical care at their clinics.

- Primary Care Services
  - FQHCs must provide primary medical care services to the population they serve. FQHCs can also apply for federal funding to provide dental care, mental health and substance abuse, or pharmaceutical services. HRSA PIN 98-23 provides the basic outline of federal expectations for FQHC activities. In the area of clinical services, these expectations include basic health services—primary care, diagnostic laboratory and radiologic services, preventive services including prenatal and prenatal services, and chronic disease screening and management services. FQHCs must ensure access to these basic health services and facilitate access to comprehensive health and social services not provided at the FQHC through case management, referrals, and other enabling services such as outreach, transportation, and interpretation. FQHCs are not allowed to use federal grant dollars to pay for hospitalization or surgery for their patients. FQHCs, though, must have arrangements in place to refer their patients for specialty services or hospitalization.
  - **Figure 9 –** top 5 procedures billed by FQHC per SFY (2004 – 2007) *MMIS data
  - **Figure 10** – top 5 diagnoses billed by FQHC per SFY (2004 – 2007) *MMIS data
  - **Figure 11 –** unduplicated consumers receiving care in a FQHC per SFY (2004 – 2007)*MMIS data
  - **Figure 12 –** average FQHC expenditure per consumer (user) per SFY (2004 – 2007) *MMIS data ****Compiling FFS expenditures and cost settlements to obtain average expenditure/consumer**
  - **Figure 13** – Kansas state map of FQHCs and consumers by county - SFY 2007 *MMIS data
  - **Figure 14 –** FQHC comparison of Medicaid expenditures by regional states *UDS data

- Reimbursement
  - Types of reimbursement methods
  - Encounter Rates
  - Rate Setting
  - Figure of FQHCs receiving each type of reimbursement
    - Prospective Payment System (PPS)
    - Cost Based System (CBS)
    - Modified Cost-Based System
  - Cost Reporting

- Quality Issues or Measures
- Evaluation and Provision of FQHCs
- Conclusions

- Recommendations

Figure 1 – Total FQHC Grant Funding by SFY

*****will be reporting SFYs 2004-2007**

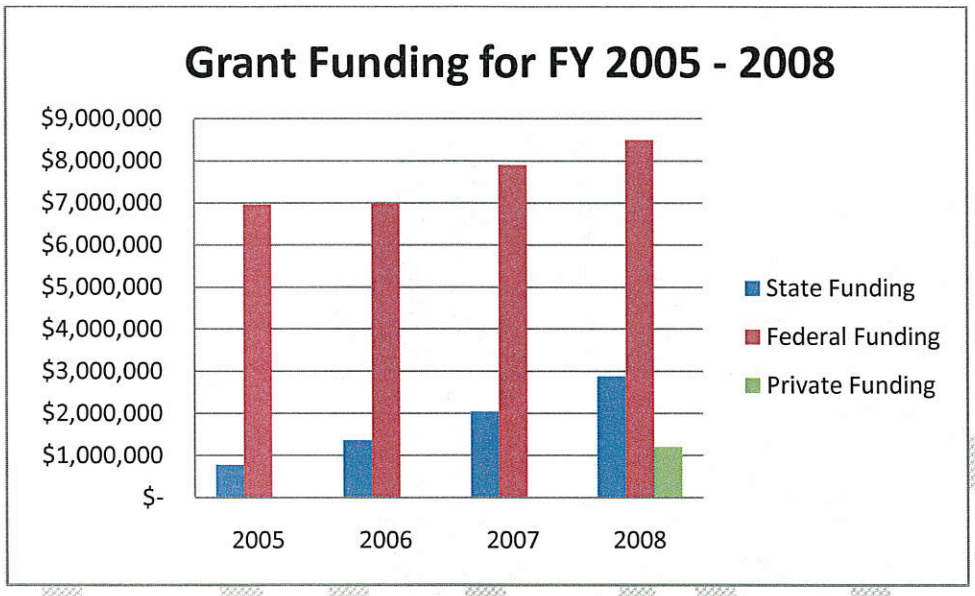
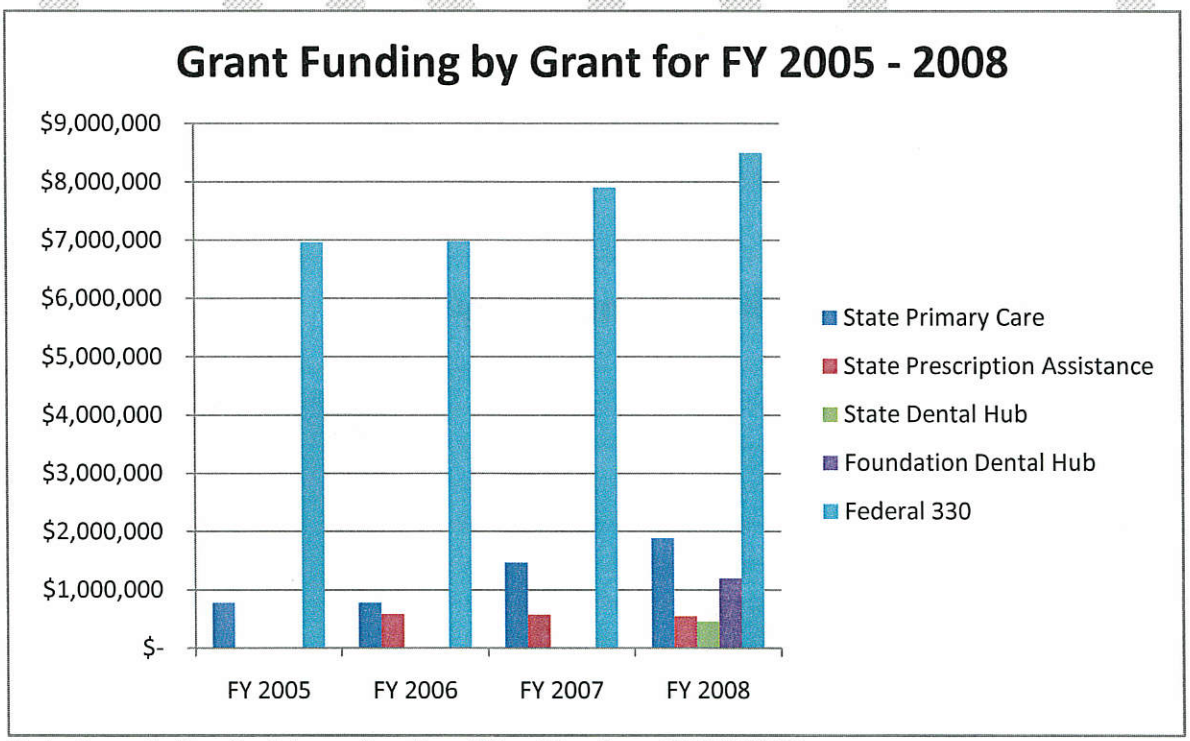


Figure 2 – Total Grant Funding by SFY

*****will be reporting SFYs 2004-2007**



State Prescription Assistance funding did not begin until SFY 2006.

State Dental Hub and Foundation Dental Hub funding did not begin until SFY 2008.

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Figure 3 – FQHC Revenue SFY 2007 (UDS data)

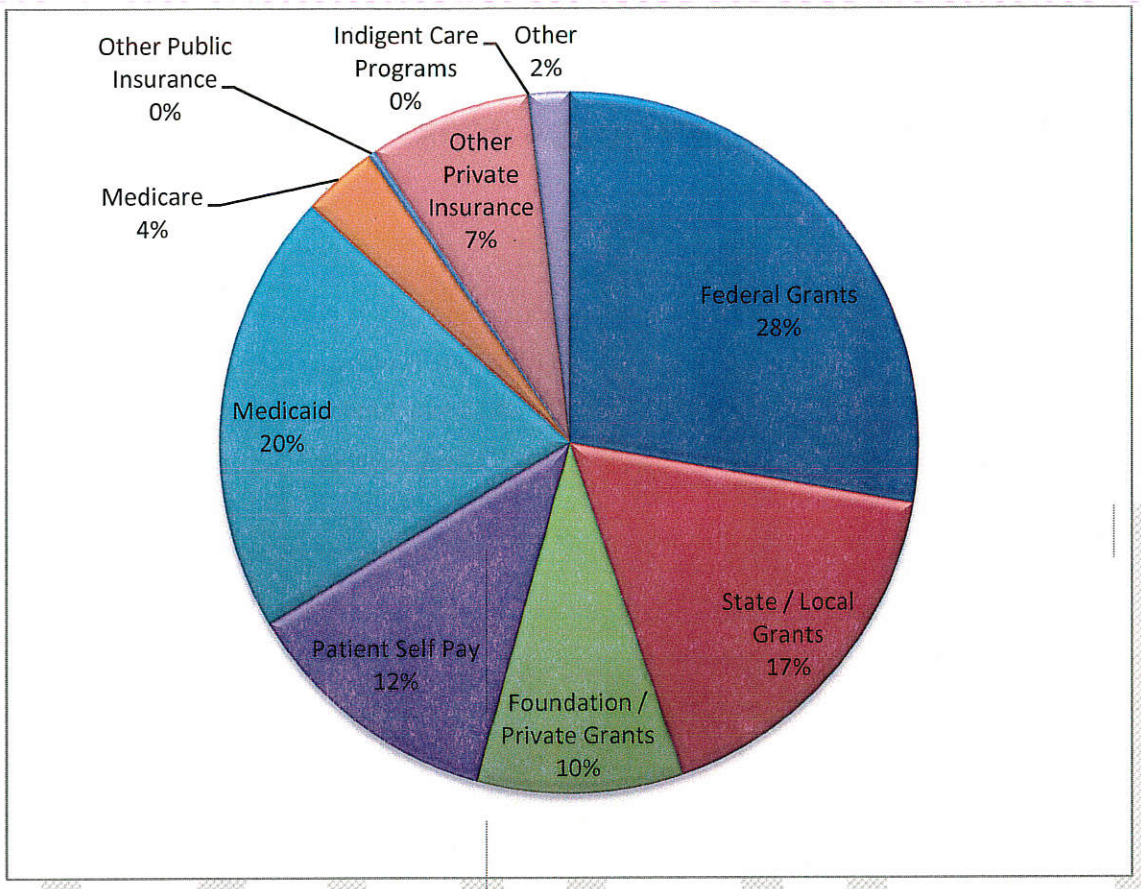
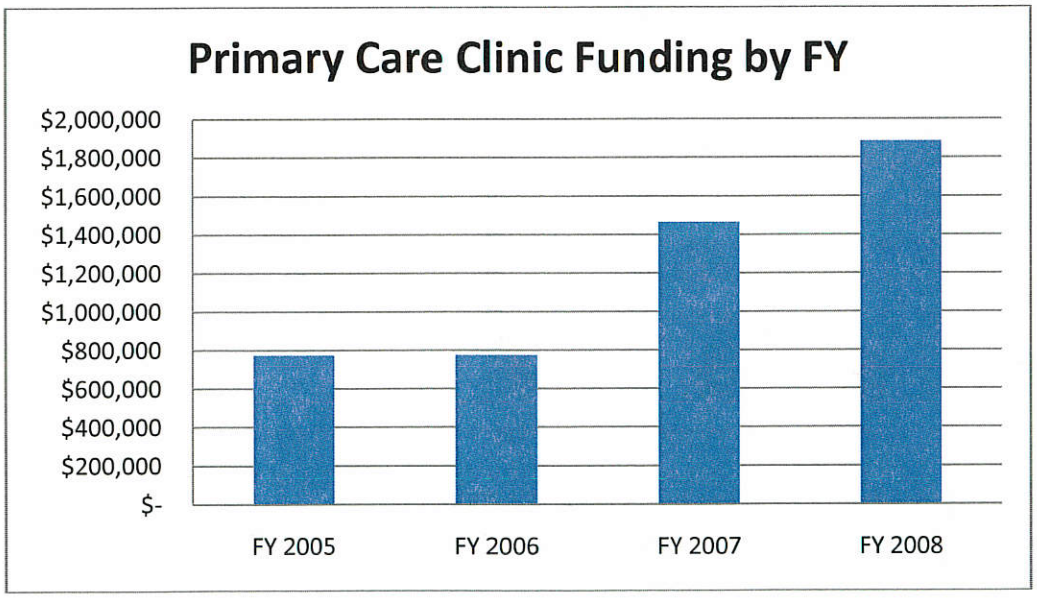


Figure 4 – Total State Primary Care Grant Funding by SFY

***will be reporting SFYs 2004-2007**



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Description of Dental Assistance Grants

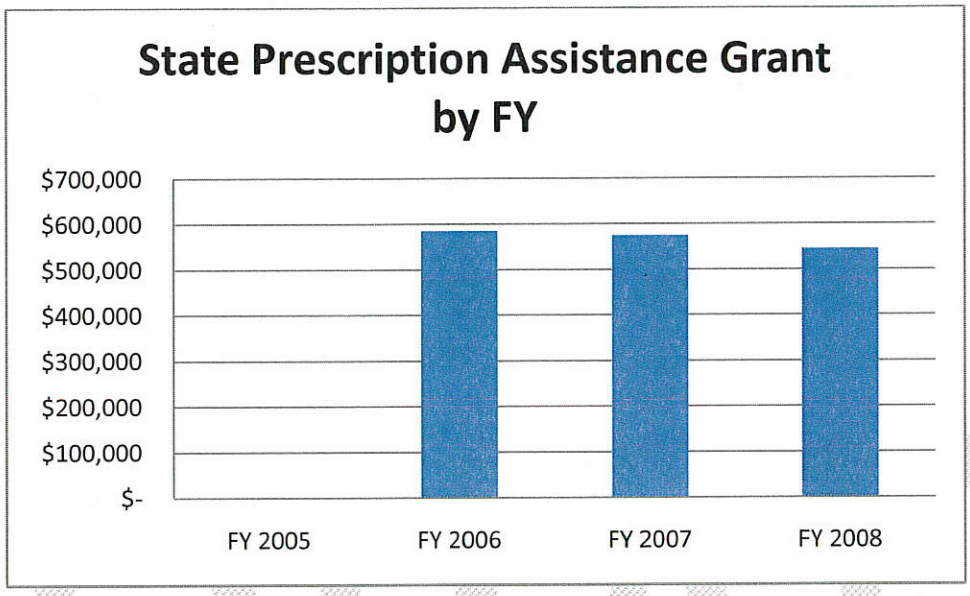
State Dental Hub and Foundation Dental Hub funding did not begin until SFY 2008.

Description of Foundation Dental Hub Grants

State Dental Hub and Foundation Dental Hub funding did not begin until SFY 2008.

Figure 5 – Total State Prescription Assistance Grant Funding by SFY

***will be reporting SFYs 2004-2007



State Prescription Assistance funding did not begin until SFY 2006.

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Figure 6 – Types of FQHC facilities - SFY 2007

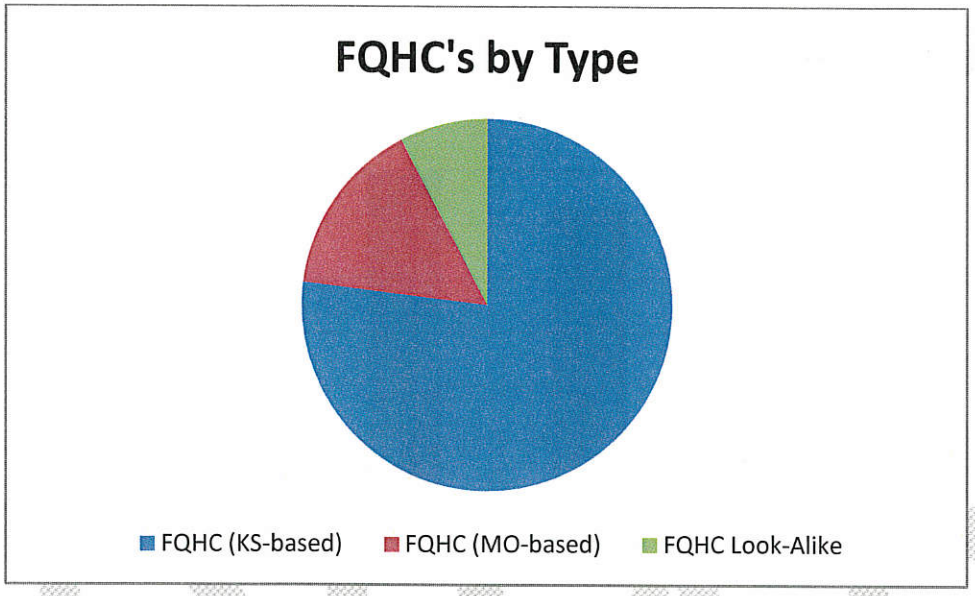
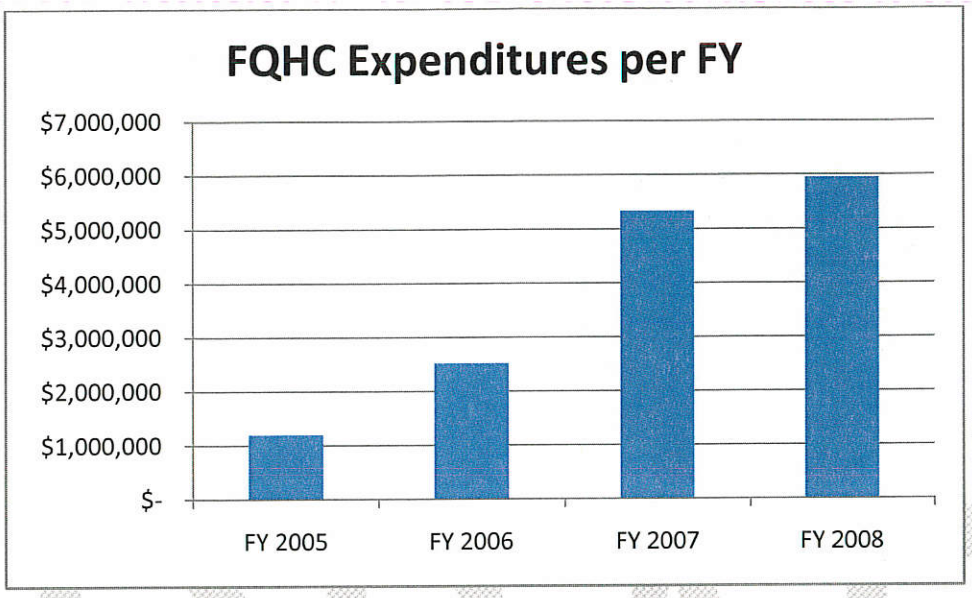
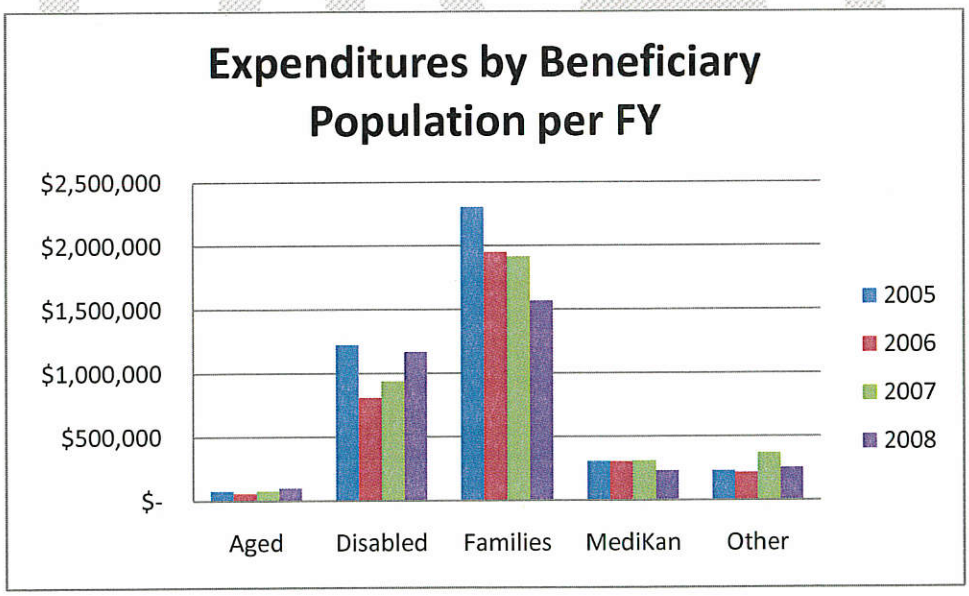


Figure 7 – Total FQHC Expenditures per SFY (including Look-Alike FQHC)



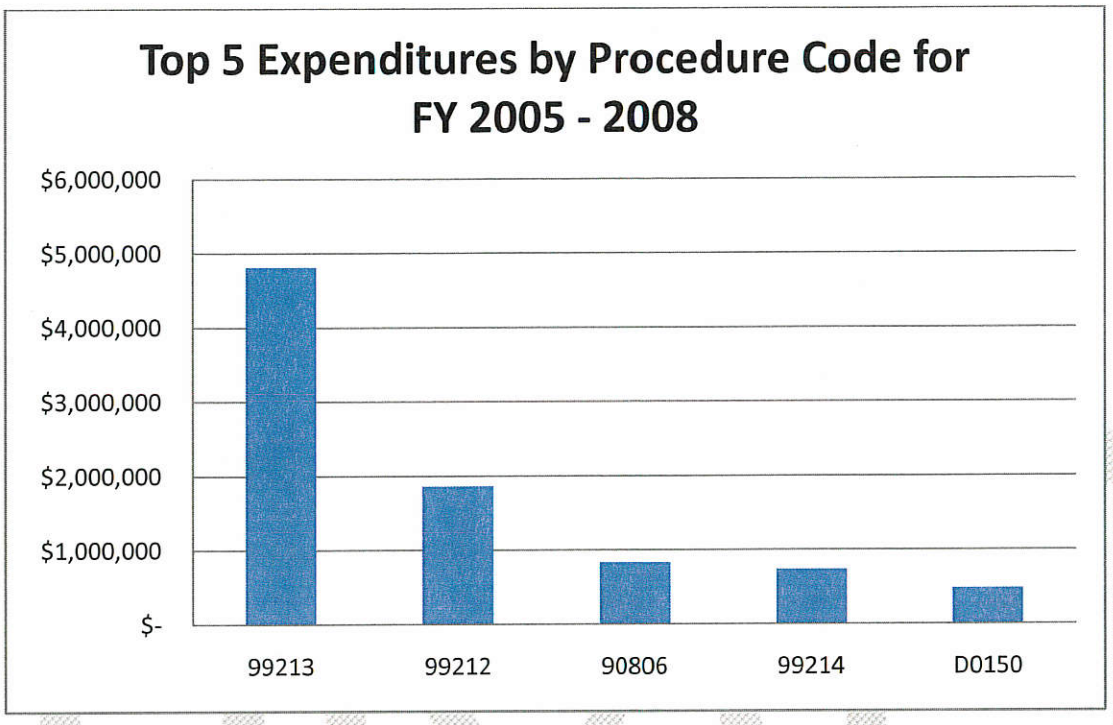
Will be adding the annual cost based settlement $ to figure 6 (above).

Figure 8 – Total FQHC Expenditures by Beneficiary Population per SFY (including Look-Alike FQHC)



United Ministries is the only Look-A-Like FQHC. They opened their FQHC in late 2007, which all billings and payment were made in SFY 2008 = $27,707.02.

Figure 9 – Top 5 Procedure Codes for FQHCs – SFY 2004 - 2007



99213 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; MEDICAL DECIS

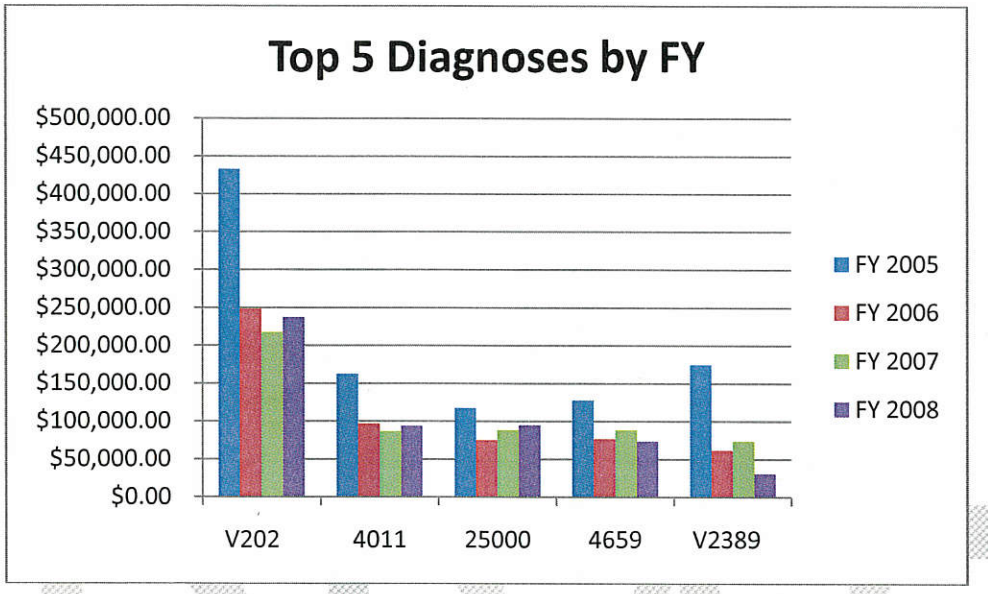
99212 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF ANESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS: A PROBLEM FOCUSED HISTORY; A PROBLEM FOCUSED EXAMINATION; STRAIGHTFORWARD MEDICAL DECISION MAKING.

90806 - INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 45 TO 50 MINUTES FACE-TO-FACE WITH THE PATIENT;

99214 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF ANESTABLISHED PATIENT, WHICH REQURIES AT LEAST TWO OF THESE THREE KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; MEDICAL DECISIONMAKING OF MODERATE COMPLEXITY.

D0150 - COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT

Figure 10 – Top 5 Diagnoses for FQHCs - SFY 2004 - 2007



V202 - ROUTINE INFANT OR CHILD HEALTH CHECK

4011 - ESSENTIAL HYPERTENSION, BENIGN

25000 - DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED

4659 - ACUTE UPPER RESPIRATORY INFECTIONS OF UNSPECIFIED SITE

V2389 - SUPERVISION OF OTHER HIGH-RISK PREGNANCY

Figure 11 – Total Unduplicated Consumers by SFY

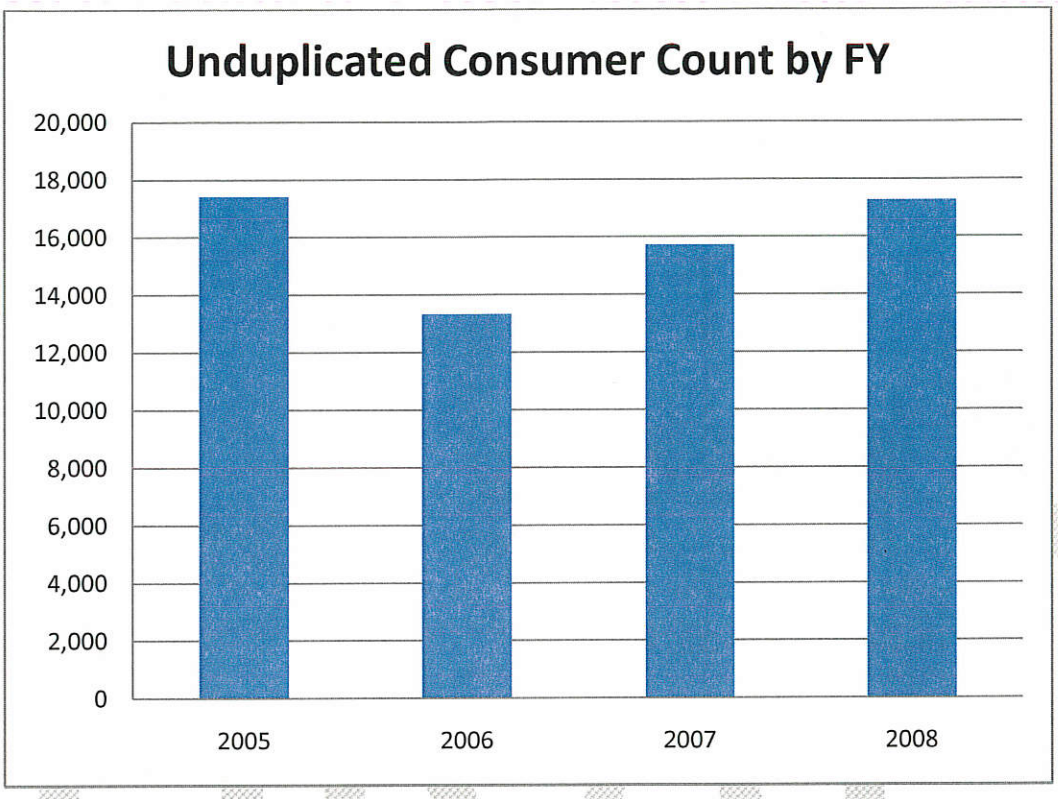


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Figure 12 – Average Expenditure per Consumer per SFY

*****Compiling FFS expenditures and cost settlements to obtain average expenditure/consumer**

Figure 13 – FQHC Map with Consumers by County – SFY 2007

*****Compiling FQHC locations to Medicaid consumers by county**

Figure 14 – Neighboring State Expenditures – SFY 2007

*****Compiling Regional State Data in UDS for SFY 2007**

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