MINUTES

JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT

November 4-5, 2010
Room 548-S—Statehouse

Members Present

Representative Brenda Landwehr, Chairperson
Senator Vicki Schmidt, Vice-chairperson
Senator David Haley
Senator Laura Kelly
Senator Roger Reitz
Representative Bob Bethell
Representative Don Hill
Representative Peggy Mast
Representative Louis Ruiz
Representative Jim Ward

Staff Present

Melissa Calderwood, Kansas Legislative Research Department
Kathie Sparks, Kansas Legislative Research Department
Nobuko Folmsbee, Office of the Revisor of Statutes
Renae Jeffries, Office of the Revisor of Statutes
Doug Taylor, Office of the Revisor of Statutes
Ken Wilke, Office of the Revisor of Statutes
Debbie Bartuccio, Committee Assistant

Conferees

Dr. Andrew Allison, Executive Director, Kansas Health Policy Authority
Cindy Hermes, Director of Governmental and Public Affairs, Kansas Insurance Department
Bill Sneed, Poisinelli, Shughart P.C.
Terry Brooks, Poisinelli, Shughart P.C.
Jerry Slaughter, Executive Director, Kansas Medical Society
Tom Bell, Chief Executive Officer and President, Kansas Hospital Association
Barb Langner, Kansas Medicaid Director
Laura Howard, Deputy Secretary, Kansas Department of Social and Rehabilitation Services
J. G. Scott, Chief Fiscal Analyst, Kansas Legislative Research Department

Ray Dalton, Deputy Secretary, Kansas Department of Social and Rehabilitation Services
Martin Kennedy, Secretary, Kansas Department on Aging
Joe Tilghman, Chairman of the Board, Kansas Health Policy Authority
Dr. William Reed, Vice-Chairman of the Board, Kansas Health Policy Authority

Others Attending

See attached list.

Thursday, November 4
Morning Session

Chairperson Landwehr called the meeting to order at 10:10 a.m. and welcomed those attending.

Dr. Andrew Allison, Executive Director, Kansas Health Policy Authority (KHPA) reviewed provisions, regulations, and programming requirements that will be required of the Kansas Health Policy Authority to implement the federal Patient Protection and Affordable Care Act (ACA) (HR 3590) and the federal Health Care and Education Reconciliation Act of 2010 (HR 4872). In addition, KHPA was asked to provide to the Committee a list of who is being contracted with to see that Kansas is in compliance with the federal requirements for HR 4872 and HR 3590.

His presentation (Attachment 1) included an overview of Kansas Medicaid and Children's Health Insurance Program (CHIP) at a glance and the Affordable Care Act (private insurance, health insurance subsidies, insurance exchanges, and Medicaid expansion). The presumed objectives of the ACA are to: define health insurance coverage, secure access to an offer of group-like insurance coverage for everyone, shift insurers from competing with consumers to competing with other insurers, and buy or subsidize minimum coverage to ensure affordability.

The state's responsibilities include: implementing insurance reforms, coordinating Medicaid and the new health insurance exchange(s), determining Medicaid's new role in the health care system, and responding to numerous grant and demonstration project opportunities. The KHPA implementation priorities include: closely monitoring and working with federal agencies; understanding and describing reform; coordinating information system changes; providing detailed analysis of state policy choices under the ACA; coordinating the planning for the exchange with Kansas Insurance Department; soliciting input from stakeholders; and informing policyholders.

Information showing an analysis of the potential impact on Kansas was provided, including a report by schramm-raleigh Health Strategy (srHS) (Attachment 2). Implications for Medicaid include: an expanded role for Medicaid in funding the safety net, reduced turnover among Medicaid beneficiaries, and requiring states to re-evaluate programs designed for the uninsured. The Affordable Care Act does not: change individual health behaviors, reduce health prices for consumers, nor reduce public spending on health care. Finally, information was provided concerning ACA requirements for coordination of enrollment and the eligibility challenges.

Vice-chairperson Schmidt asked if the young adults who currently pay low premiums will be paying higher premiums and thereby, helping to subsidize the expense of those older individuals enrolled in the new health plan. Dr. Allison replied the premiums for the young adults will subsidize the older adults, but the question is: who is paying the premium? For the low-income young adults, the federal government will be paying a good percentage of the premium through the tax subsidy.

Representative Mast asked if having an insurance policy through an employer will qualify it for a subsidy. Dr. Allison replied some employers will qualify for subsidies, such as small employers. He indicated large employers would not qualify for the subsidy, as he understands the law. He indicated, in his opinion, three years from now there will be an increase in insurance costs for some large employers. In addition, some employers may change the level of benefits provided to employees, which will have an impact on premiums paid by employers.

Representative Ward asked if there was a list of essential benefits to be provided. Dr. Allison responded there is a list and provided a copy of the list to the Committee (Attachment 3). Several questions were asked concerning rehabilitative services, particularly as they relate to children, and the timeline involved. Dr. Allison responded everything begins in January 2014. Changes could be made to the state plan to provide services not covered by the federal plan, if the state is willing to fund the services.

Cindy Hermes, Director of Governmental and Public Affairs, Kansas Insurance Department, provided information on provisions, regulations, and program requirements that will be required of the Kansas Insurance Department to address the changes required for the temporary high-risk pool program prior to the start of the 2011 Legislative Session (Attachment 4). In addition, a flier on PCIP-KS and the 2009 Annual Report of the Kansas Health Insurance Association on the profile and operating results of the Kansas High-Risk Health Insurance Pool were provided (Attachment 5).

As background, the incidence of rejection or loss of health insurance coverage due to pre-existing medical conditions prompted the Kansas Legislature to create the Kansas Health Insurance Association (KHIA) in 1992. KHIA's mission is to offer affordable comprehensive health insurance coverage to persons otherwise unable to gain coverage in the individual market because of pre-existing conditions. In keeping with the commitment, Kansas is one of 28 states to have elected to administer its own Pre-Existing Condition Insurance Plan (PCIP-KS), as opposed to a federally run plan, under the Affordable Care Act. KHIA will administrate PCIP-KS, in addition to the State High Risk Pool Plan. Summaries and descriptions of both plans were provided for educational purposes.

For an individual to qualify for the State High-Risk Pool Plan, he or she must provide proof of the following:

- Kansas residency for six months prior to application;
- Ineligibility for Medicare and Medicaid; and
- Rejection of application for insurance by two carriers because of a health condition; or
- Insurance quoted at a rate higher than the KHIA rate; or
- Acceptance for health insurance subject to an exclusion of a pre-existing disease or condition; or
- Previous individual insurance coverage involuntarily terminated for a reason other than non-payment of premiums.

Since KHIA's inception, $82 million has been assessed against the state's insurers to help cover the losses incurred by enrollees. These assessments totaled $15 million in 2007, $10.385 million in 2008, and $11 million in 2009. KHIA received $8,575,490 in available federal funds from 2003 to 2009, with $1,667,228 available for 2009. Federal grant funds to KHIA have steadily increased in recent years. The demographics of KHIA membership vary by age and gender. Overall, enrollees are 56 percent females and 44 percent males. One-third of enrollees are 60 to 64 years of age, while only 5 percent are under age 20. In recent years, the relative number of males and younger individuals joining KHIA has increased.

To qualify for PCIP-KS coverage, an individual must meet the following criteria:

- Be a U.S. citizen or person lawfully present in the United States;
- Be a resident of Kansas;
- Have been uninsured for at least six months prior to applying; and
- Have a qualifying pre-existing medical condition.

Under PCIP-KS, covered individuals must pay a deductible of $2,500, with an annual out-of-pocket limit of $5,950. Premiums are based on: where the individual lives, the individual's age, and whether the individual uses tobacco. All PCIP-KS contracts are renewable annually.

During August, September, and October 2010, KHIA received 113 applications for PCIP-KS coverage. At the end of October, there were 29 pending applications and 83 enrollees. However, it is estimated that of the 347,000 uninsured Kansans, as of December 2009, 43,722 would have been eligible for the PCIP-KS plan.

Chairperson Landwehr asked what the Kansas Insurance Department has done, has been required to do, or is working on, concerning the implementation of the national health care program. She indicated it is important, as legislators, that they understand what is being done actively by the Department; what the Department hears from other state insurance departments; what is coming; what is not coming; what changes may need to be made; and more. It will be important for the Kansas Insurance Department to communicate to the legislators information on the rules and regulations, what is being implemented, and the associated cost information.

In response, Linda Sheppard was introduced as the Department's implementation leader. The Kansas Insurance Department is having three public forums in Hays, Wichita, and Overland Park. The intent is to educate the public on what the bill is and what it does. Chairperson Landwehr responded this is the kind of information the Committee is interested in and perhaps this information could be presented at the next Committee meeting in December. It was agreed that the Department should provide a detailed presentation in December to the Committee. Chairperson Landwehr also requested the Department provide the information that will be covered in the upcoming public forums to the legislative staff, so it can be distributed to the Committee members.

The meeting recessed at noon for lunch.

Afternoon Session

Chairperson Landwehr reconvened the meeting at 2:00 p.m.

William Sneed, Poisinelli, Shughart PC, provided an overview on the Patient Protection and Affordable Care Act (ACA) (Attachment 6). A plastic card (Attachment 7) was provided with important health reform dates. Mr. Sneed proceeded to go through the changes the ACA will require of insurers with the full effect taking place in 2014. Changes effective upon enactment (March 23, 2010) included protection against premium increases, benefits for small businesses, and changes to benefit seniors. Changes within 90 days after enactment include coverage for individuals with pre-existing conditions and reduced employer health care costs. Changes effective six months after enactment (September 23, 2010) included prohibition against unwarranted rescissions, coverage for preventive services, elimination of lifetime dollar limits, appeal process, improved coverage for children, easier access to health care providers, and additional information for consumers. Changes effective January 1, 2011, include premium value and transparency. The last two pages of the testimony included a chart outlining National Association of Insurance Commissioners/Commissioner Responsibilities, listing each issue, responsibility, timeline, and citation.

Mr. Sneed also provided a booklet from the American Health Insurance Plans (AHIP) that serves as an implementation tool kit for the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 (copy located in Legislative Research Department). He pointed out a timeline in tab 5 that would be a good resource to use as the legislators go through the process.

Chairperson Landwehr requested Mr. Sneed suspend his testimony to allow Jerry Slaughter to speak, due to a schedule issue.

Jerry Slaughter, Executive Director, Kansas Medical Society, briefly summarized the impact of the health reform legislation on physician practices (Attachment 8). He indicated it is worth noting that even though this legislation has been signed into law, the health reform debate and process is far from over. And, after the elections this week, it is expected that the incoming Congress will attempt to repeal or, failing that, modify, certain aspects of the legislation.

While much of the attention up to now has been focused on the higher profile parts of the ACA, including the individual mandate and the various insurance reforms, attention will now begin to turn to the less well known provisions that, for most health care providers, really represent the essence of the reform package. While outright repeal is probably not possible, it is almost certain that Congress will begin a process of amending the legislation that will most likely never end. Mr. Slaughter emphasized that the list provided is by no means exhaustive of the provisions in the reform legislation, but just a sampling of those elements that will affect physicians.

Mr. Slaughter mentioned that the sheer number of new entities created by the ACA, their immense reach, and the broad powers delegated to the Secretary of Health and Human Services to establish a regulatory framework around them, makes any definitive assessment of the full impact of this legislation nearly impossible at this juncture.

Comments were provided concerning the following programs that will have an impact on physician practices: quality; Medicare physician payment, including primary care bonus; Medicaid primary care payment parity with Medicare; innovative practice models and the patient-centered medical home; rural general surgery bonus; geographic payment differentials; graduate medical education; National Health Care Workforce Commission; administrative simplification; alternative delivery models; Independent Payment Advisory Board (IPAB); and health exchanges. In summary, for health care providers, this is a time of uncertainty. It is very difficult to plan until the rules and regulations are finalized. Finally, in Kansas, it is going to be a challenge to have enough physicians.

Tom Bell, President, Kansas Hospital Association, provided a presentation covering the following nine general categories: health insurance; Medicare/CHIP expansion; delivery system and

reforms; Medicare/Medicaid payment changes; quality; workforce/graduate medical education; reporting information; prevention and wellness; and program integrity and oversight. Payment bundling will involve a five-year national pilot program beginning in 2013, with voluntary participation. It should include all acute and non-acute services from three days prior to admission to 30 days post discharge for eight conditions. The bundling would be composed of hospitals, physician groups, skilled nursing facilities (SNFs), and home health agencies (HHAs). The law provides that a report on hospital-acquired conditions will be provided to hospitals and will be made available to the public. Over ten years, coverage will expand to 95 percent of all Americans, or about 34 million people. Mr. Bell said regardless of the environment, we are moving toward a system that will include more transparency and accountability. His testimony listed upcoming regulations and their timeframe. In general, he thinks there will be increased coverage, delivery system reforms, payment reforms, increased transparency, and adoption of health information technology that will result in more integration across the "silos," more dollar cuts, more at-risk funding, and more public accountability and reporting (Attachment 9).

Bill Sneed again addressed the Committee with the following thoughts.

A discussion on insurance exchanges needs to get started. It does not mean an exchange is going to be created, as it is a very complex issue. The exchange cannot be one dimensional. The providers must be a component of the exchange. Need to look at how we get to the point of formulating the exchange. State privacy laws need to be reviewed. The Legislature could spend time evaluating accountable care organizations. The Legislature needs to look at liability issues, if you want the exchanges to work. For example, if a provider is part of the exchange, the provider then receives certain liability protection.

At this point, the presentation was turned to Teresa Brooks, Poisinelli, Shughart P.C. Ms. Brooks reviewed the information provided in two charts: the first chart highlighted some of the most significant provisions from 2010 through 2020 (Attachment 10), and the second chart (Attachment 11) provided a detailed list of pilots, demonstrations, and grants available, including the number of the project/grant and the eligibility and description information. According to Ms. Brooks, the challenge is for the state, federal government, and providers to work together.

Ms. Brooks emphasized the importance for the states to take the initiative to go after these grants. In answer to the question as to what other states are doing to pursue these funds, she indicated many of the states are utilizing their Washington offices or their state lobbyists to assist with the process.

After much discussion concerning the importance of assuring that Kansas is pursuing these grants, Chairperson Landwehr requested staff to provide the information from Ms. Brooks to the appropriate agencies and request information as to what they are doing to pursue them.

Ms. Brooks wrapped up with the following challenges:

- How do you attract and retain the types of providers you need?
- Does the state have the money to build the infrastructure?
- Is there going to be money for the Exchange?
- How is HHS going to develop rules?

- What will be the budget impact of Medicaid and the safety net providers?
- Does the state want to be a participant in the process, whether it is going to be through grants or identifying the issues that are going to be important to the state?
- How are you going to address the residency training issue?
- How are providers going to be responsible for outcomes if they cannot control what the patient does?

Ms. Brooks believes there are opportunities for all stakeholders to join together on these challenges.

Chairperson Landwehr thanked the Committee, staff, and conferees for their input. The meeting was adjourned at 4:15 p.m.

Friday, November 5
Morning Session

Chairperson Landwehr called the meeting to order at 9:15 a.m.

Dr. Andrew Allison, Executive Director, Kansas Health Policy Authority (KHPA), began by reviewing two handouts. One was a listing of the essential health benefits requirements (Attachment 3 from the 11/4/2010 meeting). The other was a letter dated October 13, 2010, from the Centers for Medicare and Medicaid Services (CMS) in regard to Kansas' ninth Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) request of May 27, 2010 (Attachment 12). The SPA is seeking authority to increase monthly premiums that beneficiaries or their families must pay as a condition for CHIP coverage, effective July 1, 2010. KHPA is concerned that the SPA could trigger a number of consequences, including loss of Medicaid funding. The question was raised as to whether or not there is an appeal process or other methods of having our concerns addressed. Dr. Allison indicated he is not aware of an appeal process other than what his group has already attempted, which resulted in the letter from CMS. He believes KHPA has made its case and this latest letter is its final answer. Dr. Allison, at this point, recommends the state not pursue the SPA. Chairperson Landwehr requested copies of other documents relating to this topic to aid in further explanation of the process that has occurred to this point in order to provide clarity and assist in developing an action plan on this topic.

Dr. Allison then provided an overview of the medical records project (Attachment 13). The American Recovery and Reinvestment Act of 2009 (ARRA) health information technology (HIT) provisions afford Kansas and Medicaid providers with an opportunity to leverage federal funding of provider incentive payments, planning efforts, and Medicaid information systems development. These funds are for the development and "meaningful use" of electronic health record (EHR) technology and health information exchange (HIE) to improve patient care throughout the state.

The KHPA, as the designated state Medicaid agency, will develop and submit to the Center for Medicare and Medicaid Services (CMS) a Medicaid HIT vision document, referred to as the State Medicaid HIT Plan (SMHP), describing the role of the Medicaid program in the state's overall plan to advance and achieve meaningful use of electronic health information.

KHPA participated actively in the development of the statewide HIE plan, *i.e.*, the "Strategic and Operational Plan," which is under review by the federal government. The statewide HIE plan has now been handed to the recently convened Kansas Health Information Exchange (KHIE) for implementation. The KHIE is a public-private partnership, established by Executive Order, and charged with overseeing federally sanctioned HIE efforts in the state. KHPA sits on the KHIE Board of Directors and will work with the state HIE coordinator, the KHIE, and a wide range of Medicaid stakeholders to complete and then implement the SMHP.

The following topics were reviewed:

- American Recovery and Reinvestment Act (ARRA) HIT Requirements for States;
- CMS's Phased Approach to Meaningful Use of Electronic Health Information;
- KHPA Goals for HIT and HIE;
- State Medicaid HIT Plan (SMHP) with Timeline through June 2011; and
- Charts on Medicaid and Medicare Incentive Payments.

Barbara Langner, Medicaid Director, Kansas Health Policy Authority, provided an update on the verification of prescription drugs to avoid abuse project (Attachment 14). According to Dr. Langner, the non-medical use or abuse of prescription drugs is a serious and growing public health problem both in Kansas and across the country. Addressing the increase of prescription drug abuse is a focus nationwide. Thirty-four states have a Prescription Monitoring Program (PMP) currently active, and programs in nearly a dozen more states, including Kansas, will be active soon. PMPs allow prescribers and pharmacists to review a patient's full medication history prior to prescribing or filling a narcotic prescription, rather than having only the patient's history with that individual practitioner to review. Use of PMPs decreases a potential abuser's ability to get multiple prescriptions from multiple prescribers and pharmacies for personal use or sale. The Kansas PMP is poised to become active within the next few months. The Kansas Board of Pharmacy will be responsible for operation of the new system.

The Patient Protection and Affordable Care Act includes a provision that all prescribers must be enrolled in Medicaid. This provision's effective date is January 1, 2011. Under current Medicaid policy, the medication prescriber does not have to be enrolled in Kansas Medicaid. Implementation of this provision will provide additional controls on prescribing of controlled substances.

Current Status: Dose optimization of long-acting narcotics was fully implemented on 11/2/2010. Policies regarding short-acting and long-acting narcotics have been written and are in the system design phase.

Other topics included in the handout:

- Reduce Coverage of Certain Over-the-Counter Medications;
- Pursue More Aggressive Pricing for Specialty Drugs;
- Limit First Fill of a Name Brand Prescription to 15 Days;
- Expand Drug Use Reviews, Provider Education, and Peer Intervention;

- Implement 4 Brand Name Prescription Per Month Limit and Tiered Formulary; and

- Enhanced PA (Prior Authorization) System.

Laura Howard, Deputy Secretary, Department of Social and Rehabilitation Services (SRS), provided an update on the Food Assistance Program (Attachment 15). The program is a federal program administered by SRS, which provides a monthly benefit to eligible low-income households to assist in purchasing food for home consumption. The program is administered at the federal level by the United States Department of Agriculture (USDA). At the federal level, the Food Stamp Program was changed to State Nutrition Assistance Program, or SNAP. In Kansas, this program is called the Food Assistance Program. The program currently serves 277,579 persons, of which 46 percent are children.

Benefits to increasing participation in the Food Assistance Program include helping more low-income families with their food and nutrition needs, as well as transition to self-sufficiency. In addition, the increased food-buying power generated by the program generates economic activity, supports the local and state economy, and supports farming in Kansas. Every $5 in food assistance generates $9.20 in economic activity.

Objectives of the Family Nutritional Program (FNP) Include:

- Improve dietary quality by providing information on dietary guidelines and My Pyramid;

- Increase fruit and vegetable consumption – a fruit and vegetable newsletter is mailed with each food assistance review;

- Increase food resource management skills – "food shopping on a budget"; and

- Increase participation in physical activity.

Food assistance benefits are issued electronically on the Vision card. Food items eligible for SNAP are determined by Food and Nutrition Services (FNS). FNS also establishes the standards for stores to meet to be eligible to accept SNAP benefits. In 2010, 14 "Farmers Markets" in Kansas had the ability to access the Vision card for fresh, local fruit and vegetable purchases.

SNAP program integrity is maintained through quality control activities performed by both state and federal agency staff. The ALERT system receives daily transaction records from Electronic Benefit Transaction (EBT) processors and conducts analysis of patterns in the data, which indicate potential fraudulent activity by stores. The Food Stamp Act mandates that each state operate a Quality Control System to monitor and improve the administration of the Supplemental Nutrition Assistance Program. Other SNAP fraud Initiatives within the state include the review and analysis of the following EBT reports: EBT Report of Excess Vision Card Replacements, EBT Report of Benefits Spent Out-of-State, and EBT Report of Excessive Large Dollar Purchases. Cases identified within these reports result in further inquiry and investigation, as warranted. Overall, the Food Assistance Program is an effective and critical support for low-income Kansans.

There was a question as to whether someone else can use another person's card. Ms. Howard indicated there are authorization approvals for qualified people to use another person's card.

As an example, someone who is homebound could authorize another individual to purchase their food using the card.

Chairperson Landwehr recessed the meeting at 11:50 a.m.

Afternoon Session

The meeting reconvened at 1:17 p.m.

J. G. Scott, Chief Fiscal Analyst, Kansas Legislative Research Department, provided a review of consensus caseload estimates for fiscal years 2011 and 2012 (Attachment 16). The Division of the Budget, Department of Social and Rehabilitation Services, Kansas Health Policy Authority, Department on Aging, Juvenile Justice Authority, and the Legislative Research Department met on October 28, 2010, to revise the estimates on human services caseload expenditures for FY 2011 and to make initial estimates for FY 2012. The caseload estimates include expenditures for Nursing Facilities, Regular Medical Assistance, Temporary Assistance to Families, General Assistance, the Reintegration/Foster Care Contracts, psychiatric residential treatment facilities, and out-of-home placements. A chart summarizing the estimates is included.

The estimate for FY 2011 is increased by $49.3 million from the State General Fund and $98.0 million from all funding sources. The new estimate for FY 2012 then increases by $248.8 million from the State General Fund, and $78.7 million from all funding sources. The combined increase for FY 2011 and FY 2012 is an all funds increase of $176.7 million and a State General Fund increase of $298.1 million.

The estimates include Medical Assistance expenditures by both the KHPA and SRS. Most health care services for person who qualify for Medicaid, MediKan, and other state health insurance programs were transferred to the KHPA on July 1, 2006, as directed in 2005 Senate Bill 272. Certain mental health services, addiction treatment services, and services for persons with disabilities that are a part of the Regular Medical Assistance Program remain in the budget of SRS.

Additional details were provided concerning the projections for FY 2011 and FY 2012.

Ray Dalton, Deputy Secretary of Disability and Behavioral Health Services, SRS, presented information regarding six Home and Community Based Service (HCBS) waivers that provide services to persons with disabilities, including the number of individuals served, and funding for each of the programs. A chart was included with more details on the waivers. He also briefly addressed the potential impact of the federal Patient Protection and Affordable Care Act as it relates to the Medicaid services managed by SRS (Attachment 17).

As background, Medicaid waivers are federally approved requests to waive certain specified Medicaid rules. For instance, federal Medicaid rules generally allow states to draw down federal Medicaid funds for services provided in institutions for persons with severe disabilities. Many of the community supports and services provided to persons with disabilities such as respite care, attendant care services, and assistive services, are not covered by the regular federal Medicaid program. HCBS waivers give the state federal approval to draw down federal Medicaid matching funds for community supports and services provided to persons who are eligible for institutional placement, but who choose to receive services that allow them to continue to live in the community.

The Centers for Medicare and Medicaid Services (CMS) requires that the cost of services paid through HCBS waivers be, on the average, less than or equal to the cost of serving people in comparable institutions.

Updates were provided on the following topics:

- Developmental Disability (DD) Waiver;
- Physical Disability (PD) Waiver;
- Traumatic Brain Injury (TBI) Waiver;
- Technology Assisted (TA) Waiver;
- Serious Emotional Disturbance (SED) Waiver; and
- Autism Waiver.

SRS Fee Fund – Over the past several years, SRS fee fund balances have been used to fill the gap between available SGF and waiver spending and the funds allocated for the HCBS Waivers. The fee fund balance has now been depleted and SRS will be $11 million short for FY 2012. SRS will be requesting an enhancement to replace the $11 million shortfall with the next budget submission. SRS's options regarding changes that may be made to fill this gap are limited by federal regulations that have been implemented through the Recovery Act and the Affordable Care Act. These regulations do not allow states to change the waiver eligibility requirements without loss of federal funding. Under the Recovery Act, the number of persons served by the waivers may not drop below the number of individuals that were being served on July 1, 2008. The only options that are available to SRS to control spending are through serious rate reductions and then to evaluate what additional service limitations could be implemented.

Mr. Dalton also addressed the potential impact of federal health care reform. Much of the detail regarding requirements for states in implementing the Patient Protection and Affordable Care Act is yet unknown, because regulations have not yet been issued. From what is known so far, he thinks Kansas is positioned to implement the various provisions of the act. The various state agencies (Kansas Insurance Department, KHPA, SRS, KDHE, KDOA) that would be involved with implementation are all assessing the provisions of the act, are prepared to review regulations as they are issued, and are actively reviewing and applying for grant opportunities under the act as they become available.

Secretary Jordan has established an internal health reform steering Committee to ensure we are evaluating the act and its potential impact on existing SRS programs and processes. SRS is actively tracking federal regulations and regularly reviewing health care reform funding and grant opportunities reported through Federal Funds Information for States (FFIS). Each division of SRS is reviewing and following the act's provisions as they become applicable, and is reviewing information, reviews, and commentary about the act and its implementation options developed by various program-area experts.

The most significant impact of the act relates to maintenance of effort requirements associated with HCBS waiver programs in Kansas. Under the act, the requirement is that states maintain eligibility standards, methodologies and procedures that were in place as of March 23,

2010. This requirement for adults will expire when the state exchange system is operational, except for populations with income below 133 percent of poverty, the requirement expires on January 1, 2014 (when all non-elderly non-disabled adults with incomes up to 133 percent of poverty will become mandatory eligibles). For children, the maintenance of effort requirement is retained until the end of 2019. Unlike the ARRA, which made compliance with its maintenance of effort provision a condition to receiving enhanced FMAP, compliance with the maintenance of effort provision in the Act is a condition to receiving any federal financial participation for the program out of compliance, during the period in which the requirement applies.

Additional potential impact, especially in substantial areas related to covered services, will not be known until benefit packages are established. Changes in benefit packages may have a significant impact on Kansas' mental health and substance abuse treatment service programs, which have been designed around the idea of a large number of uninsured individuals needing access to comprehensive behavioral health services. Additional impact on the HCBS waiver programs in Kansas continues to be evaluated, and will depend in part upon how some of the new waiver options under the Act are operationalized. And finally, through our review of the Act thus far, from an SRS perspective, there does not appear to be a need for any statutory changes in conjunction with the various provisions of the Act.

Bill McDaniel, Program and Policy Commissioner, Kansas Department on Aging, provided an overview on the Medicaid expense projections for FY 2011 and FY 2012 for the following four program caseload projections: HCBS-FE, Nursing Facility, PACE, and Targeted Case Management. Charts also included: Kansas LTC Medicaid Expenditures; Kansas LTC Medicaid Average Caseload; and Kansas LTC Medicaid Monthly Expenditure (Attachment 18).

Senator Schmidt requested Mr. McDaniel have the cost information on the actual savings of PACE for the Committee's December meeting.

Scott Brunner, KHPA Chief Financial Officer, presented an update on KHPA budget, caseload, and policy initiatives (Attachment 19). Three pie charts illustrated FY 2011 Revised KHPA Budget, All Funding Sources, FY 2011 Revised KHPA Budget, State General Fund Only, and FY 2011 Submitted State General Fund Operating Budget, $17.2 million (cut 25 percent since FY 2009). Action taken to meet the approved budget included: layoff of seven staff, reduced selected staff pay; eliminated 20 contract employees and replaced with four reallocated KHPA staff; and froze overtime at Eligibility Clearinghouse.

Cost Recovery Audit Contract included: Developed a Request for Proposal to identify and collect Medicaid overpayments; Medicaid recovery services are consistent with the forthcoming Medicaid regulations requiring states to use recovery audit services; other state agency programs are included in the RFP to identify potential savings from interagency and multiple service categories; State Employees' Health Plan recoveries can be proposed; RFP was developed with all agencies' input, closed on October 29; and expect to award the contract by December and start the contractors' work by January.

Cost savings and efficiency request for information included: developed a request for information to seek products and services from vendors that could reduce Medicaid costs; services are not specified, but might include care coordination, disease state management, technology, and data services, and other similar items; can propose products that integrate service systems or cut across Medicaid agencies; and responses were due by October 29. The KHPA Board and the Legislature will review the policy options, and KHPA may proceed with a Request for Proposal process to acquire services that have potential for cost savings.

The 2010 Legislature reduced the Health Wave budget by $11 million ($2.8 million from the State General Fund), directing KHPA to increase premiums by $40 per family per month. KHPA submitted the required plan amendments to CMS effective for July 1, 2010. CMS has indicated that it will not approve the $40 premium increase.

There was a question concerning whether or not information is provided to the Medicaid patients so they can review and confirm they really received the services. Dr. Allison responded that with Medicaid patients, since there is no patient payment responsibility, there is generally no information sent to them for review. It was suggested perhaps a pilot program could be tried to send information to recipients for their review to assure the services have really been provided. A related question concerned what percentage of patient charts is reviewed. Dr. Allison indicated he would get back with the Committee concerning these questions.

Dr. Allison provided the update on the HealthWave Clearinghouse backlog (Attachment 20). The clearinghouse is a centralized processing center which manages family medical eligibility determinations. The clearinghouse is operated by a private vendor through a competitive contract. The contractor for the first ten years was Maximus and now is Policy Solutions, Inc. (PSI). According to federal regulations, an eligibility determination must be completed on an application within 45 days of the date it is received.

Dr. Allison explained that contributors to the current clearinghouse backlog began in calendar year 2009 and continued into 2010, when a number of factors converged to create a large backlog. These factors included:

- Increased volume of Kansans applying for Medicaid and CHIP due to economic climate;
- Expiration of the HealthWave clearinghouse contract resulting in new procurement and transition of functions from Maximus to PSI between June 2009 and January 2010;
- Expansion of CHIP eligibility to 250 percent of the 2008 federal poverty level;
- Reduction of $430,000 SGF, $981,538 AF in the PSI contract due to the November 2009 Governor's Allotments; and
- PSI startup performance inefficiencies.

Since 2009, KHPA has taken a number of steps to find a solution to the backlog of applications and the resulting delays in eligibility experienced by thousands of applicants. In August 2009, KHPA began applying approximately $450,000 AF unexpectedly returned from a former contractor to increased overtime at the Clearinghouse. Nonetheless, as a result of the Governor's November 2009 allotment, those funds had to be reapplied to other agency operations. KHPA worked to simplify the eligibility process and to identify several areas of performance inefficiency on the part of the Clearinghouse contractor. This resulted in October 2010, at no additional charge to the state, PSI added 23 additional staff dedicated to processing its portion of the backlogged applications. But despite these efforts, the backlog remained very large, prompting a federal response in mid-2010.

Addressing Centers for Medicare and Medicaid (CMS) Concerns: On April 22, 2010, KHPA received a letter from James Scott, Associate Regional Administrator for Medicaid and Children's Health Operations for CMS. In the letter, CMS noted that Kansas was out of compliance with its

state Medicaid plan and with federal requirements regarding timely determination of eligibility. As a result, CMS requested the filing of a corrective action plan outlining how Kansas planned to resolve the issue. On July 30, 2010, KHPA sent to CMS the corrective action plan to resolve the HealthWave clearinghouse backlog, which employs a three-pronged approach:

- Implement system modifications to hasten the processing of applications;
- Adopt CMS-approved eligibility policy options to simplify the eligibility determination process; and
- Seek financial resources from multiple sources to increase application processing capacity, which include seeking private funding from philanthropic foundations, submitting budget enhancement requests to the Governor and Legislature, and seeking a favorable Children's Health Insurance Program Reauthorization Act (CHIPRA) bonus payment decision.

On August 11, 2010, KHPA was notified by CMS that Kansas had been awarded a $1,220,479 CHIPRA bonus award. In the month following receipt of the funding through the CHIPRA bonus, 16 temporary workers were hired as staff for the eligibility Clearinghouse. They began training on September 20, 2010. In addition, further system enhancements were implemented in September and a number of simplifications to the eligibility determination process were adopted, including: streamlined verification of the contractor work; piloting of the pre-populated review form for adult beneficiaries to renew their eligibility; and exploration of implementation of the interface with SSA to confirm citizenship declarations. On October 25, 2010, KHPA initiated passive renewals for child Medicaid and CHIP beneficiaries. Over the last month, the additional resources coupled with changes in policies have resulted in an increase of 5,000 applications/reviews processed and a retirement of 1,500 over-45-days applications from the backlog. As of November 1, the backlog numbered 17,786 over 45 days, but KHPA is now on track to resolve it by March 2011.

There was discussion concerning the information provided. Some questions raised by the Committee for which Dr. Allison will provide answers to the Committee at the December meeting include: Why the contract was changed from Maximum to PSI; a workflow chart illustrating how a HealthWave application is processed; statistics concerning how many denied applicants have lost their cases when appealed; and finally, KHPA will provide an update on the status of the backlog.

Chairperson Landwehr expressed her concerns about the fact that Kansas families and children are not being provided the access to the insurance that has been promised, as evidenced by the huge backlog and lack of required funding. It is extremely important that the Committee understand the funding required so assistance can be provided during the budget process.

The Kansas Health Policy Authority, by law, will sunset on July 1, 2013, and was asked to explain what the current structure brings to the process and to make recommendations for change to the current structure. Comments were provided by Joe Tilghman, current Chairman of the Board (no written comments were provided). He indicated recommendations on the current structure would be premature. He also offered the following three thoughts:

- If he were Governor, he would be very nervous about having as large a program as Medicaid not under his direct control. With the multitude of health-related decisions, he strongly believes success in Kansas will require a much stronger and more political structure than the current one can provide.

- The agency needs to do two things well in 2011. First, it needs to identify all the choices the State will have to make in implementing health reform, laying out all the options and their costs. While all this is happening, there will be many changes over the next ten years and then the state will have to comply with the necessary changes in process and law. Second, while accomplishing these tasks, the state "needs to keep the trains running on time with regard to the day-to-day operations of the Medicaid program, and the state employees' health insurance program."

- Over the past five years, the Board has done a "pretty good job" of running the programs at KHPA. An exceptionally strong state agency with a good management team has been built. He said the Board could be changed but expressed caution concerning making any wholesale change in the leadership team or a restructuring.

Dr. William Reed, Vice-Chairman, KHPA Board, said the state is facing a monumental change in health care and he believes the Board serves as a liaison between the agency and the Legislature. The value of the Board is that it understands what the patient wants or deserves and wants to see people get better health care. As a Board member, he would like to feel more a part of the Committee's ideas and assist the Legislature with meeting its goals.

Vice-chairperson Schmidt expressed her appreciation to Joe Tillman, who will be retiring, for his past service on the Board.

Representative Bethell reported that the Kansas Association for the Medically Underserved has offered to step up and facilitate a review with state agencies and other organizations to come together to see what can be done to acquire some of that grant money for the State of Kansas. For the December meeting, he requested the organization provide an update on what it has done to get things moving in the right direction.

Chairperson Landwehr reported the Insurance Department has already scheduled Commissioner Praeger to be here on the afternoon of December 8. She also requested each agency involved have a representative at the meeting to answer questions. If members have specifics on what should be covered at that meeting, it should be provided to Kathie Sparks of the Kansas Legislative Research Department. Ms. Sparks indicated SRS and the Department on Aging also will return to the December meeting.

There was discussion concerning the previous topic of the CMS letter concerning its opinion on the premium increase issue and how best to approach it. Chairperson Landwehr asked Dr. Allison if he could request a better explanation from CMS as to why it is denying the premium increase, so he can explain the decision in more detail to the Legislature. Dr. Allison indicated he thinks the KHPA has gone as far as it can go in pursuing this question. He will provide information on this topic in the transition process.

The following additional handouts were provided to the Committee, but not discussed:

- Requirements on Maintenance of Effort (Attachment 21);

- Letter from CMS dated August 19, 2009 to State Medicaid Director (Attachment 22);

- Copy of Subtitle E – Affordable Coverage Choices for All Americans (Attachment 23); and

- CHIP Cost Sharing information (Attachment 24).

The meeting was adjourned at 4:50 p.m. The next meeting was scheduled for December 8, 2010.

Prepared by Debbie Bartuccio
Edited by Kathie Sparks

Approved by the Committee on:

December 8, 2010
(Date)

Joint Committee on Health Policy Oversight

DATE: 11-4-10

NAME	REPRESENTING
Carol A Curtis	AstraZeneca
Susan Zalenski	J & J
[illegible]	[illegible] & Assoc.
Heather Morgan	LMK
Bill Saeed	Polsinelli Law Firm
Cindy Ermes	KID
Linda Sheppard	KID
Gary Robbins	KOA
Bernd Koops	Hein Law Firm
Dodie Wellshear	KAFP
Jenni Roe	KCSL
DEBORAH STERN	KHA
Cathy Harding	KAMU
ASHLEY WALLACE	KAMU
Connie Hassell	KAMU
Gail Unruh	w/ Rep Don. Hill
Jasmine Spittles	Guest of Rep. Don Hill
[illegible]	Wellpoint/Unicare
JOHN C. BOTTENBERG	CMFHP
Lorrie Ann Brown	Aetna

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Joint Committee on Health Policy Oversight

DATE: 11-4-10

NAME	REPRESENTING
Tom Bruno	HP
Chad Moore	CMFHP
Bob Finuf	CMFHP
Travis Love	Little Gov't Relations
Sarah Tidwell	KSNA
Rachel Whitten	KS Reporter
Andrew Monford	KHPA student
Patrick Woods	SRS
Suzanne Wikle	KAC
Suzanne Cleveland	KHI
Tom Wilson	LPA
Katrin Osterhaus	LPA
Michelle Butler	Capitol Strategies
Micki King	Health Care Access Clinic
Marie Carpenter	KAHP
Belinda Vierthaler	State LTC Ombudsman
Tolla White	Kansas African American Affairs Comm
Mary Beth Blake	Polsinelli Shughart PC
Amy Campbell	Kansas Mental Health Coalition

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Joint Committee on Health Policy Oversight

DATE: 11-4-10

NAME	REPRESENTING
Bruce Witt	Via Christi Health
Paul Jacobs	United Healthcare
Chad Austin	KHA

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Health Policy Oversight

DATE: 11-5-10

NAME	REPRESENTING
Anne Marie Hughes	SKIL
Kris Kelm	KID
Susan Zalenski	J+J
Carol Curtis	A-2
Kevin Davis	KID
Jenna Rose	KCSL
Barb Hubbard	Pharma
Rob Merrill	Kennedy + Assoc
Kim Johnson	summsured
Nikki King	Health Care Access Clinic
Berend Koops	Heim Law Firm
Chad Austin	Ks Hosp Assoc
Bob Williams	Ks Assoc Osteopathic Medicine
Bruce Witt	Via Christi Health
Mike Hutfless	KAMU
Jared Jones	United Healthcare
Jean Miller	Capitol Strategies
Matt Casey	GBA
Peter Hancock	KHPA

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Implementing the Affordable Care Act: Agency Priorities and State Policy Choices

Joint Health Policy Oversight Committee

November 4, 2010

Dr. Andrew Allison, KHPA Executive Director

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Kansas Medicaid and CHIP at-a-glance

- Medicaid: Free coverage for very-low income families, elderly and disabled
  - Pregnant women and infants up to 150% FPL
  - Children: 100% or 133% of FPL, depending on age
  - Elderly and Disabled: income limits vary, 100 – 200% FPL
  - Adult Parents and Caregivers: approximately 30% FPL
  - "Medically Needy" – Adults with incomes above threshold with large medical bills
  - Childless adults are not covered
- CHIP
  - Income limit: 250% of 2008 FPL (appr. 241% current FPL)
  - Premiums: $20 - $75 per-family, per-month, depending on income (CMS will reject a state plan amendment to raise these by $40-100 per month)
  - "HealthWave:" State contracts with MCO; pays flat, capitated rate for each beneficiary – also serves 141,000 Medicaid children and parents

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Brief Summary of the ACA

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Federal Health Reform: Two New Laws

- **Patient Protection and Affordable Care Act of 2010 (ACA)**
  - Based on Senate health reform legislation
  - Passed March 23, 2010
- **Health Care and Education Affordability Reconciliation Act of 2010**
  - Added some elements of House reform proposals to the Senate version
  - Passed April 2, 2010

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Affordable Care Act: Private Insurance

- **Changes taking effect within six months**
  - New, temporary re-insurance pool for early retirees
  - Create new high-risk pools for those with pre-existing conditions
  - Provide dependent coverage for children up to age 26 for all policies
  - Eliminate lifetime limits on dollar value of coverage
  - Prohibit insurers from retroactively dropping coverage except for fraud
  - Prohibit pre-existing condition exclusions for children
  - Up to a 35% subsidy for small employers (under 25) to provide insurance
- **Changes taking effect in 2014**
  - Guaranteed offers of insurance to all eligible consumers
  - Eliminate any premium differences based on health risks or gender and limit age-rating to a premium ratio of 3-1
  - Income –related subsidies for both premiums and cost-sharing
  - Create new insurance marketplace through "exchanges"

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Affordable Care Act: Health Insurance Subsidies

- **Sliding scale premium subsidies based on income**
  - Under 150% FPL: Max. of 2-4% of income
  - 150-200% FPL: Max . of 4-6.3%
  - 200- 400% FPL: Max . of 6.3-9.5%
- **Cost-sharing protections based on income**
  - Under 150% FPL: Max. of 6% of covered costs
  - 150-200% FPL: Max. of 15%
  - 200-400% FPL: Max. of 27-30%
  - Separate income-related out-of-pocket caps
- **Insurance reforms, subsidies, and cost-sharing protections interact**
  - Some out-of-pocket costs shift into premiums
  - Raw premiums for young adults will go up
  - Young adults are most likely to qualify for subsidies and protections
- **Federal government bears limited risk for premium increases**
  - After 2014, increases in subsidies will be limited to growth in income
  - After 2018, subsidy growth will also be tied to inflation

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Affordable Care Act: Insurance Exchanges

- Creates state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP)
- States may default to federal government to establish the exchange
- Administered by governmental agency or non-profit
- Subsidies available only through the new exchanges
- Available to individuals and small businesses (up to 100 employees)
- States can allow larger businesses to buy coverage in SHOP in 2017
- States may form regional exchanges with other states or within the state
- Federal funding available to establish exchanges through 1/1/2015

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Affordable Care Act: Medicaid Expansion

- Maintenance of effort for Medicaid eligibility: current Medicaid eligibility rules are set in stone (only until 2014 for adult eligibility above 138% of poverty)
- Medicaid is expanded in 2014
- All non-disabled under 65, up to 138% FPL (includes childless adults)
- Feds cover 100% of cost for expansion group in 2014 through 2016
  - 2017: 95%
  - 2018: 94%
  - 2019: 93%
  - 2020 and thereafter: 90%
- Some state flexibility in covered benefits for newly-eligible
  - Must meet minimum standards set by Federal government
  - Minimum standards may entail new benefits like "habilitation" and "rehabilitation"
  - ACA language indicates that states can opt to provide additional benefits to the expansion population

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Affordable Care Act: Children's Health Insurance Program

- Require states to maintain current income eligibility levels for children in Medicaid and CHIP until 2019
- Extend funding for CHIP through 2019
- Benefit package and cost-sharing rules continue as under current law
- In October 2015, federal CHIP match rate increased by 23 percentage points
- Federal allotments for CHIP funding remain in place, limiting potential enrollment
- Eligible children who can't enroll due to limited funding will be eligible for tax credits in the state exchanges

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Affordable Care Act: Presumed Objectives

- **Define health insurance coverage**
  - Minimum coverage includes standard benefits and implies affordable cost-sharing
  - Includes prescription drugs and mental health parity
- **Secure access to an offer of group-like insurance coverage for everyone**
  - Eliminates differences in insurance premiums due to the health risks of individuals or co-workers
  - Private, portable insurance for those buying as individuals and employees
- **Get insurers to compete with each other rather than consumers**
  - New exchanges should facilitate price shopping and ease enrollment
  - Stabilize private insurance markets through required participation
- **Buy or subsidize minimum coverage to ensure affordability**
  - Greatly expand Medicaid to cover the lowest-income Americans
  - Cost-sharing protections and Federal tax subsidies for premiums aid others

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Implementation

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Affordable Care Act Implementation: State Responsibilities

- **Implement insurance reforms**
  - decide whether to accept the responsibility and opportunities that come with the establishment of an exchange
  - define what kind of competition they want inside the exchange
  - decide how to govern these new and potentially dominant health insurance markets
  - decide whether, and how, to use the buying power and regulatory influence they have been given in Federal legislation
- **Coordinate Medicaid and the new exchange(s)**
  - ensure access to coverage
  - seamless transitions between different sources of coverage
  - link Medicaid's insurance market with the new private insurance market?
- **Determine Medicaid's new role in the health care system**
  - simplify eligibility and select benefit package for Medicaid expansion group
  - set Medicaid payment rates and secure access to providers
- **Respond to numerous grant and demonstration project opportunities**

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Affordable Care Act Implementation: KHPA Priorities

- **Closely monitor and work with federal agencies**
  - **Federal health reform panels**
  - **National Association of Medicaid Directors**
- **Understand and describe reform**
  - **Estimate Potential Impact on Kansas (May 2010)**
- **Coordinate information system changes**
  - **Build a new platform for Medicaid and the Exchange (RFP released October 2010)**
- **Detailed analysis of state policy choices under the ACA**
  - **$250,000 in grants from five Kansas grant makers (matched 1-for-1)**
  - **Create options for Medicaid benefit packages and to simplify Medicaid eligibility (RFP for contract analysis pending; analysis due mid-2011)**
- Coordinate planning for the exchange with Kansas Insurance Department
- Solicit input from stakeholders and inform policymakers

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Analysis of Potential Impact on Kansas

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Affordable Care Act Estimates: Key Assumptions

- **Purpose of the analysis is to inform Kansas decision makers**
  - Analysis is not designed to address the question of federal reform
  - Analysis does not include populations the Federal government has already assumed responsibility for (Medicare)
  - Analysis does not estimate impact on the Federal budget, nor Federal taxes paid by Kansans
- **State spending is best understood in a more comprehensive estimate**
  - Employer-sponsored coverage offsets Medicaid (for those eligible for both)
  - Impact of coverage mandate affects Medicaid participation
  - Overall reduction in the number of uninsured could have an impact on ongoing spending for state programs designed for the uninsured
- **State fiscal impact is dependent on future state decisions**
  - Programs designed to secure access for the uninsured may need to be reviewed
  - Estimates examine state spending under a range of future policy choices, including potential increases in Medicaid provider payment rates
  - Estimates are needed to help policymakers with these difficult choices over the next three years
- **Results are consistent with national estimates by the Congressional Budget Office (CBO) and the Centers for Medicare and Medicaid Services (CMS)**
  - 6% residual rate of un-insurance
  - Small net impact on employer-sponsored coverage
  - Small positive impact on total health spending

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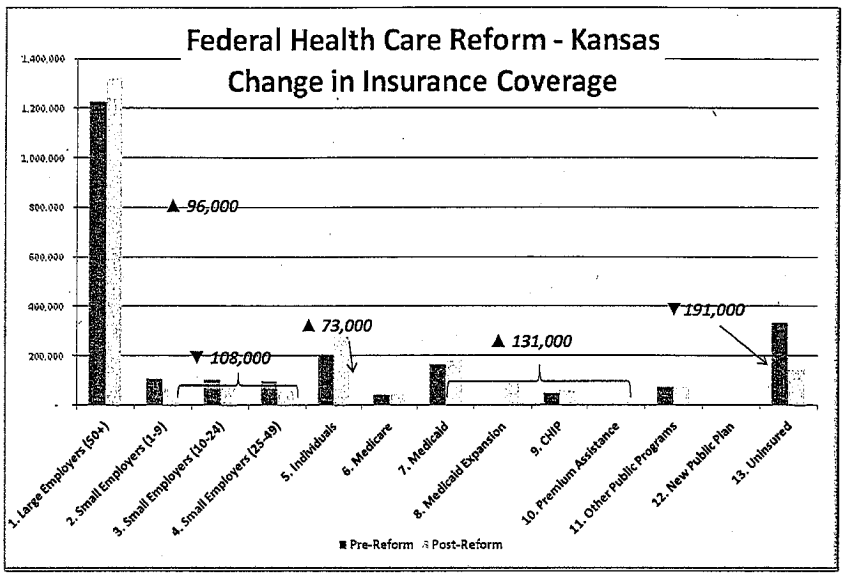
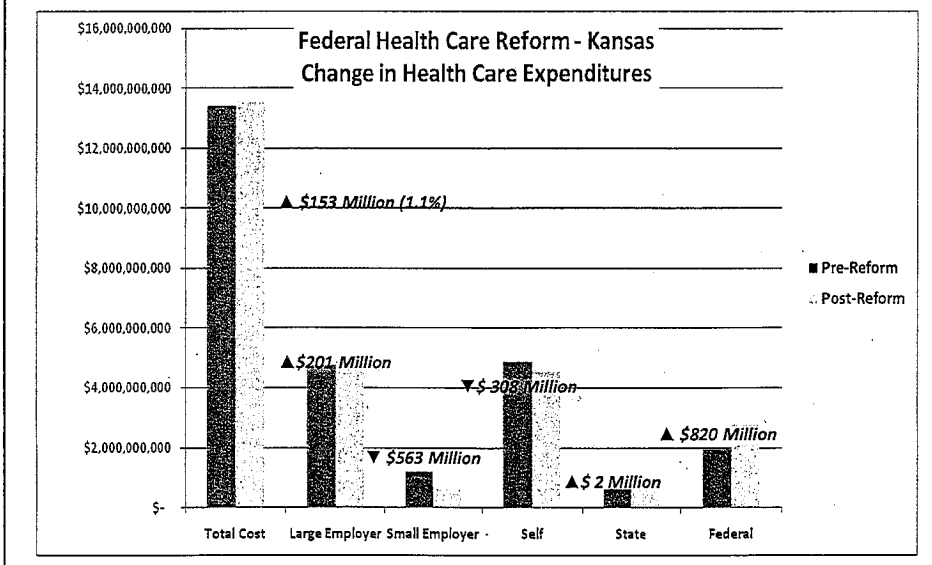
Affordable Care Act Estimates: Source and Process

- **Coverage and basic cost estimates produced by *schramm-raleigh Health Strategy* (now *Optumas*) with funding from the United Methodist Health Ministry Fund**
  - Additional analysis of impact on state spending by KHPA
- **"Point" estimates**
  - Represents the potential outcome of Federal reforms based on actuarial advice and national benchmarks
  - Assume the state takes no additional actions to expand coverage nor reduce spending (except to eliminate MediKan)
- **"Upper bound" estimates of coverage**
  - Assumes residual rate of un-insurance is 4% rather than 6%
  - Other potential costs, such as provider rate increases, are identified in separate KHPA analysis
- **Estimates include increased cost of program administration**
- **Estimates expressed in constant dollars using 2011 as a base**
- **Limitations**
  - Estimates reflect impact on under-65 population only
  - Estimates do not reflect reductions in Medicare payments included as funding sources in health reform legislation
  - Do not replicate other analyses of the impact on Federal taxpayers


Federal Health Care Reform - Kansas
Change in Insurance Coverage
1,400,000
1,200,000
1,000,000
800,000
600,000
400,000
200,000
-
▲ 96,000
▼ 108,000
▲ 73,000
▲ 131,000
▼ 191,000
1. Large Employers (50+)
2. Small Employers (1-9)
3. Small Employers (10-24)
4. Small Employers (25-49)
5. Individuals
6. Medicare
7. Medicaid
8. Medicaid Expansion
9. CHIP
10. Premium Assistance
11. Other Public Programs
12. New Public Plan
13. Uninsured
Pre-Reform
Post-Reform


Federal Health Care Reform - Kansas
Change in Health Care Expenditures
$16,000,000,000
$14,000,000,000
$12,000,000,000
$10,000,000,000
$8,000,000,000
$6,000,000,000
$4,000,000,000
$2,000,000,000
$-
▲ $153 Million (1.1%)
▲ $201 Million
▼ $563 Million
▼ $ 308 Million
▲ $ 2 Million
▲ $820 Million
Total Cost
Large Employer
Small Employer
Self
State
Federal
Pre-Reform
Post-Reform

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Affordable Care Act: Impact of Enhanced Match Rates on Medicaid in 2020

	All Funds Spending ($ millions)	Average State Share	State Spending ($ millions)
Baseline spending	1,541	40.2%	619
Spending with reform	1,972	31.5%	621
Change	+432	-8.7%	+2
Percent change	28.0%		0.3%

Notes: Reflects point estimate. Includes spending on medical care only. Excludes administrative costs and changes in DSH spending.

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Affordable Care Act: Impact on State Spending in 2020

State options regarding direct spending for the safety net*

	Maintain all state spending on the safety net	Reduce state spending on the safety net by half	Eliminate state spending on the safety net
Point estimate plus 5% provider rate increase	$35 M	$12 M	-$8 M
Upper bound estimate of coverage	$7 M	-$16 M	-$35 M
Point estimate	$4 M**	-$19 M	-$39 M

Additional risk: +/- $15 million variance in true cost of Medicaid benefit package. Impact subject to state choice and federal regulation over covered benefits.

*Options are illustrative and do not reflect the opinions of KHPA staff, nor the KHPA Board. State spending totals for the uninsured through the safety net are preliminary ($40-$45 million annually).
**To the estimate from the actuaries model, this adds new administrative costs and reductions in DSH spending.

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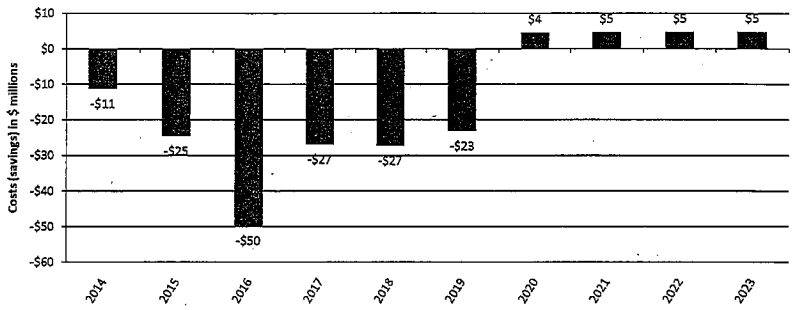
Affordable Care Act: Net Impact on State Spending 2014-2023

Net Impact of Federal Health Reform on State Spending:
Point estimates: no additional reduction in State spending on the uninsured



Note: Reflects point estimates. Assumes no additional reduction in state spending on the uninsured, and no increase in Medicaid provider rates.

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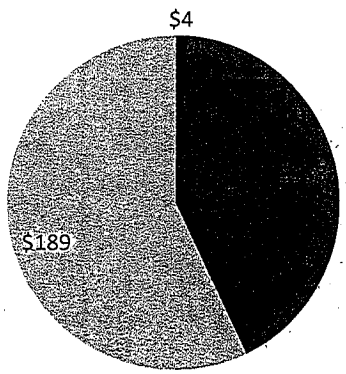
Sources of Growth in Medicaid Spending 2011 vs. 2020



- Federal reforms (non-disabled; non-aged)
- Growth in number of disabled and aged (4.3% per year)
- Baseline growth in costs (3% per year)

(estimates in $ millions)

Note: Assumes no additional reduction in state spending on the uninsured, and no increase in Medicaid provider rates.

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Affordable Care Act: Implications for Medicaid

- **Expanded role for Medicaid in funding the safety net**
  - Medicaid will become the major payer for some providers
  - Approach to payment and cost control will be more important
- **Reduced turnover among Medicaid beneficiaries**
  - Higher, uniform income threshold will increase continuity
  - Larger, more stable Medicaid population increases financial returns to the state for investments in prevention and care management
- **States will need to re-evaluate programs designed for the uninsured**
  - The state helps mitigate uncompensated care through Medicaid disproportionate share hospital (DSH) payments, direct state subsidies to health care and mental health clinics, special Medicaid reimbursements to clinics and critical access hospitals, etc.
  - Health reform will bring at least $150 million in new health spending in the state
  - Many of the remaining uninsured will be eligible for subsidized coverage
  - Cultural expectations for coverage and individual responsibility may change
  - Key questions:
    - ❖ How much of current state spending on the safety net is devoted to the uninsured?
    - ❖ How much uncompensated care will remain?
    - ❖ What is the state's ongoing responsibility for those costs?

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Affordable Care Act: What It Does Not Do

- **Change individual *health behaviors***
  - Directly confront the true cost drivers in health care: smoking, over-eating, inactivity
  - Make sure individuals face the right incentives as consumers of health care
- **Reduce *health care prices* for consumers**
  - Expand the number of providers to create more price competition?
  - Fill in "missing" provider markets with changes in training and/or licensing?
  - Enact malpractice reforms?
- **Reduce *public spending* on health care**
  - Public spending on health care is unsustainable at the present rate of growth
  - In Kansas, increases in public spending will be driven by the existing program
  - Will require changes in the delivery of care, e.g., technology and coordination
  - Federal reform created new opportunities, but leaves concrete steps to states

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Transforming the Eligibility Process

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ACA Requirements for Coordination of Enrollment

- Sections 1413 and 2201 of the ACA include requirements to ensure integration of eligibility and enrollment between Medicaid and the exchange
  - States must make available a common web-based application for Medicaid, CHIP, and the subsidies and cost-sharing protections available in the exchange.
  - State exchanges must screen applicants for Medicaid and CHIP eligibility, and state Medicaid and CHIP programs must accept these referrals and enroll these individuals in the appropriate program without further review of eligibility.
  - State Medicaid programs must ensure that ineligible applicants are screened for eligibility for subsidies in state exchanges, and that those found eligible are enrolled in a plan through the exchange.
- States may contract with their state Medicaid agency to determine eligibility for premium subsidies and cost-sharing protections within the exchange
- Given the duplication of effort and the financial disputes that could arise from two competing eligibility processes, I expect most states will take this option

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Assessing Kansas' Readiness for the Eligibility Challenge

- Combined "system" for Medicaid, cash assistance, food stamps, and child care often doesn't speak with itself
- Aging mainframe system has "hardening of the arteries"
  - Programs written in a dead language
  - Paper applications are required: mail-in or hand carry
  - Labor-intensive reviews and work-flow management
  - Off-system calculations and "work-arounds"
- Very difficult to support additional eligibility categories
- Lack of a simple consumer interface limits outreach
- Can support on-line electronic adjudication of eligibility for neither Medicaid nor for subsidies in the exchange
- "Scalable" neither in the complexity nor the size of programs it can support
- Tens of thousands of un-enrolled eligible individuals

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Implementing the Affordable Care Act: The Eligibility Challenge

- **Twice the scale.** The state needs an on-line real-time system to support eligibility determinations for 33% larger Medicaid population and another Medicaid-sized exchange population receiving at least $600 million in income-based premium subsidies annually.
- **One-third the time.** Business processes must support concentrated enrollment of the expanded population in an annual "open enrollment period" beginning October 2013.
- **Perfectly integrated.** The state needs a single, integrated eligibility process for health insurance provided through Medicaid and the exchange, communicate in real time with federal information portal, and needs to maintain or improve integration with human service eligibility process.
- **Ready in three years.** The new system must be operational between July and October 2013.

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Kansas' Solution: HRSA Grant to Pave the Way

State Health Access Program (SHAP) Grant from Health Resources and Services Administration (HRSA)

- Final grant in a series of HRSA/SHAP grants
- Kansas previously had 2 SHAP grants, documenting the over-riding problem of eligible, but un-enrolled children
- Grant is to provide support for starting up programs that extend coverage to the uninsured population
- SHAP grants will demonstrate, proof-test, and de-bug key elements of federal reform

KHPA's project to cover the uninsured

- Awarded multi-year grant
- Includes funds to build IS base for modern approach to outreach
- Out-stationed eligibility workers to recruit and train community outreach partners
- Pilot expansion of coverage to young adults

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Changing Needs in Medicaid Eligibility and Outreach

Current Model

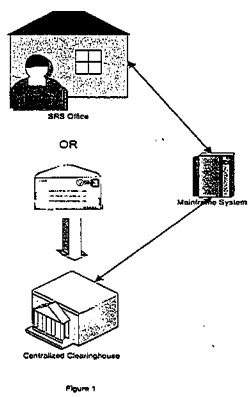

Figure 1

New Model

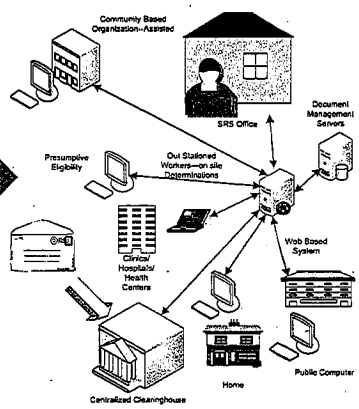

Figure 2

30

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Planned Eligibility System for Health Insurance Coverage

HRSA grant objectives

- Create full "vertically integrated" eligibility system for Medicaid and the exchange
- Create online application for Medicaid/CHIP and presumptive eligibility screening tool for community partners
- Use full electronic adjudication to reduce error and increase the number and speed of determinations

Additional benefits and design criteria

- Provide a base for seamless eligibility determinations between health insurance products including subsidies for participants in insurance exchanges under the ACA
- Provide platform that can be used as a building block for the future Medicaid Management Information System (MMIS) – appr. 2015
- Work together with human service agency (SRS) to create a common, flexible platform to build – in stages – an integrated process for administering and coordinating means-tested programs, e.g., cash assistance & food stamps

31

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http://www.khpa.ks.gov/

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schramm-raleigh HEALTH STRATEGY

UNITED METHODIST HealthMINISTRYFund

Kansas:
Impact of Federal Health Reform

Preliminary Estimates on Cost and Coverage

Steve Schramm
Gabe Smith
schramm-raleigh HEALTH STRATEGY (srHS)

Kansas Health Policy Authority Topeka, Kansas May 18, 2010

Discussion Outline

2-2

- Funding and Background
- SHRP Model
  - Data and Baseline
  - Structure
  - Flowchart
- Federal Health Care Reform – Key Drivers
  - Coverage
  - Cost
- Scenario Modeling
- Impact
  - Coverage
  - Cost
- Questions

Funding and Background

- Funding - generously provided by the United Methodist Health Ministry Fund

The Health Fund's Mission
Healthy Kansans through cooperative and strategic philanthropy guided by Christian principles.

- Background – **srHS** has conducted statewide health reform analyses/modeling in multiple states, including:
  - Connecticut
  - Kansas
  - Maine
  - Massachusetts

SHRP Model

Data and Baseline

- Data Sources
  - Current Population Survey (CPS) (2008 Data)
  - Medical Expenditure Panel Survey (MEPS) (2006-2008 Data)
  - Kansas Insurance Department Survey (2006 Data)
  - Medicaid Expenditure Data (2008-2010 Data)

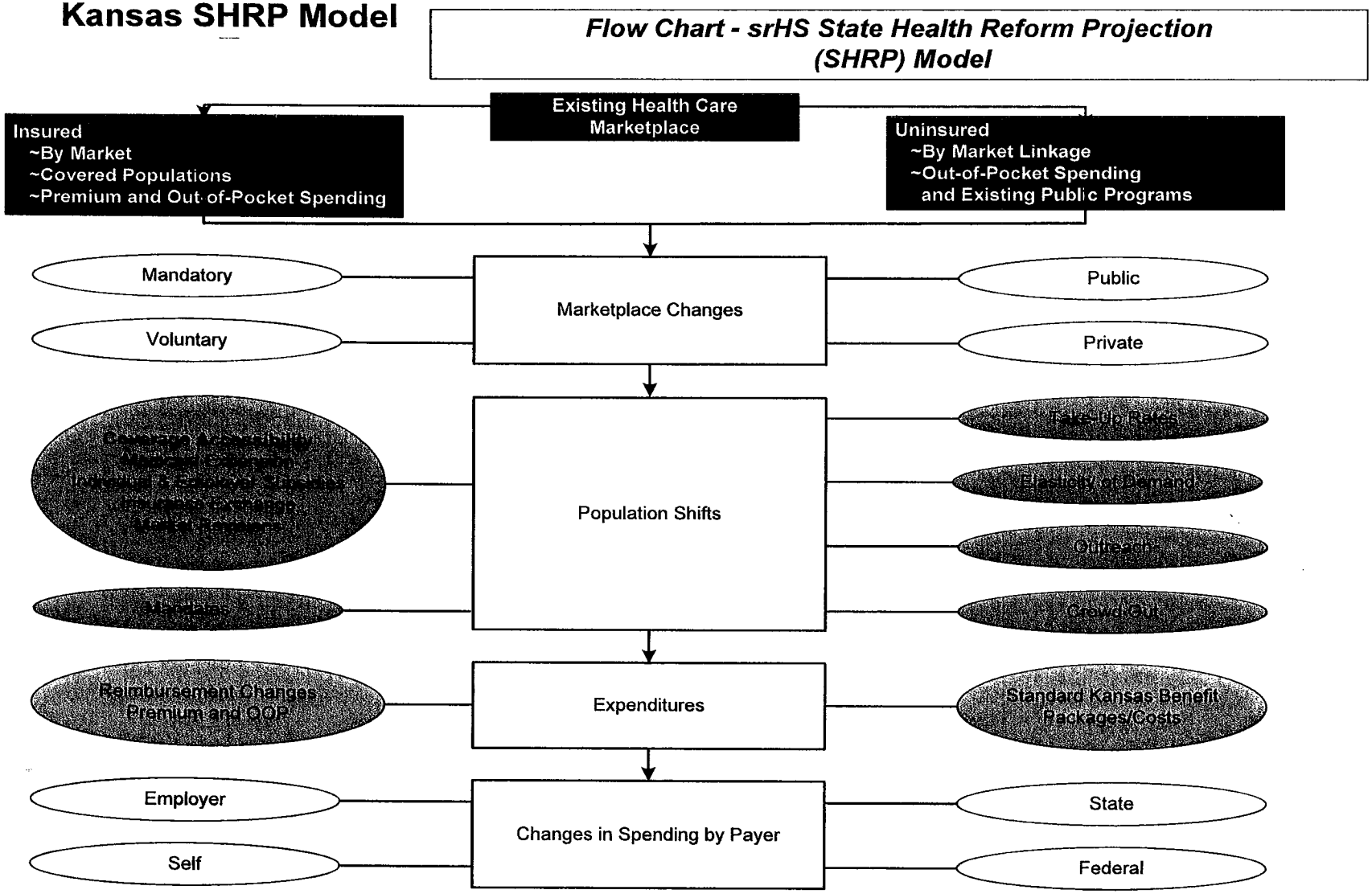
- Baseline – Point-in-Time Model
  - 2011 Dollars
  - Full Implementation as of 2020

SHRP Model

Structure

- Components within the Model
  - Employer (ER) Size (1-9 ,10-24, 25-49, 50+)
  - Medicaid/CHIP Programs
    - Program Expansion/Contraction by Federal Poverty Level (FPL)
    - FMAP Changes
  - Individual and Employer Subsidies by FPL and ER Size
  - Market Revisions
    - Combination of Markets
    - Guarantee Issue and Pre-Existing Conditions Exclusions
  - Government-Sponsored Public Plan
  - Individual and Employer Mandate by FPL and ER Size
  - Reimbursement Adjustments and Cost Sharing Provisions
  - Residual Uninsurance by FPL

Kansas SHRP Model



Federal Health Care Reform

Key Drivers of Coverage and Cost Impacts

Coverage	Cost
Economics of Options • Choices Available to Individuals • (Dis)Incentives to Small Businesses	Subsidies * • Eligibility • Affordability of Coverage
Changes in FPL Eligibility Levels * • Medicaid Expansion to 138% FPL	FMAP * • CHIP FMAP of 95% • Expansion FMAP of 90%
Economics of Penalties • Individuals - $695 vs. $5,500 premium • Employers - $2,000 vs. $3,600 premium	Reimbursement • One-Time Adjustment or Beginning of Fundamental Shift

** Fixed Parameters with FHCR Legislation*

SHRP Scenario Modeling - Results

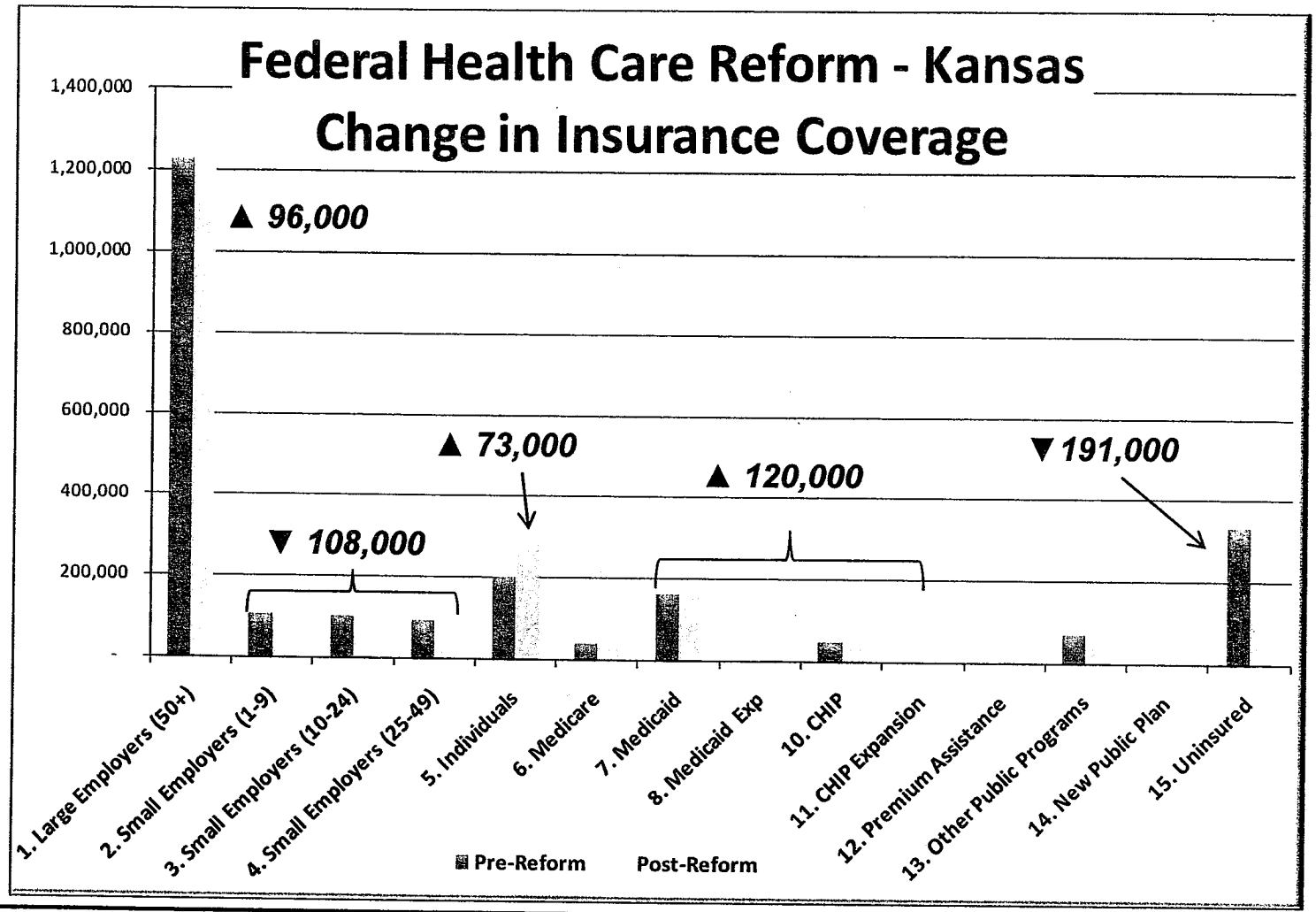
Provider Reimbursement and Residual Uninsurance

State Expenditures (▲Increase/▼Decrease) and Uninsured Remaining		
Scenarios	6% Residual Uninsurance	4% Residual Uninsurance
5% Increase to Reimbursement	*Scenario 1 (Sc1)* ▲ $32.9 Million 143,000 Uninsured	*Scenario 3 (Sc3)* ▲ $36.3 Million 98,000 Uninsured
0% Increase to Reimbursement	*Scenario 2 (Sc2)** ▲ $2.0 Million 143,000 Uninsured	*Scenario 4 (Sc4)* ▲ $5.3 Million 98,000 Uninsured

** The remainder of the graphs and figures represent Scenario 2 (Sc2)*

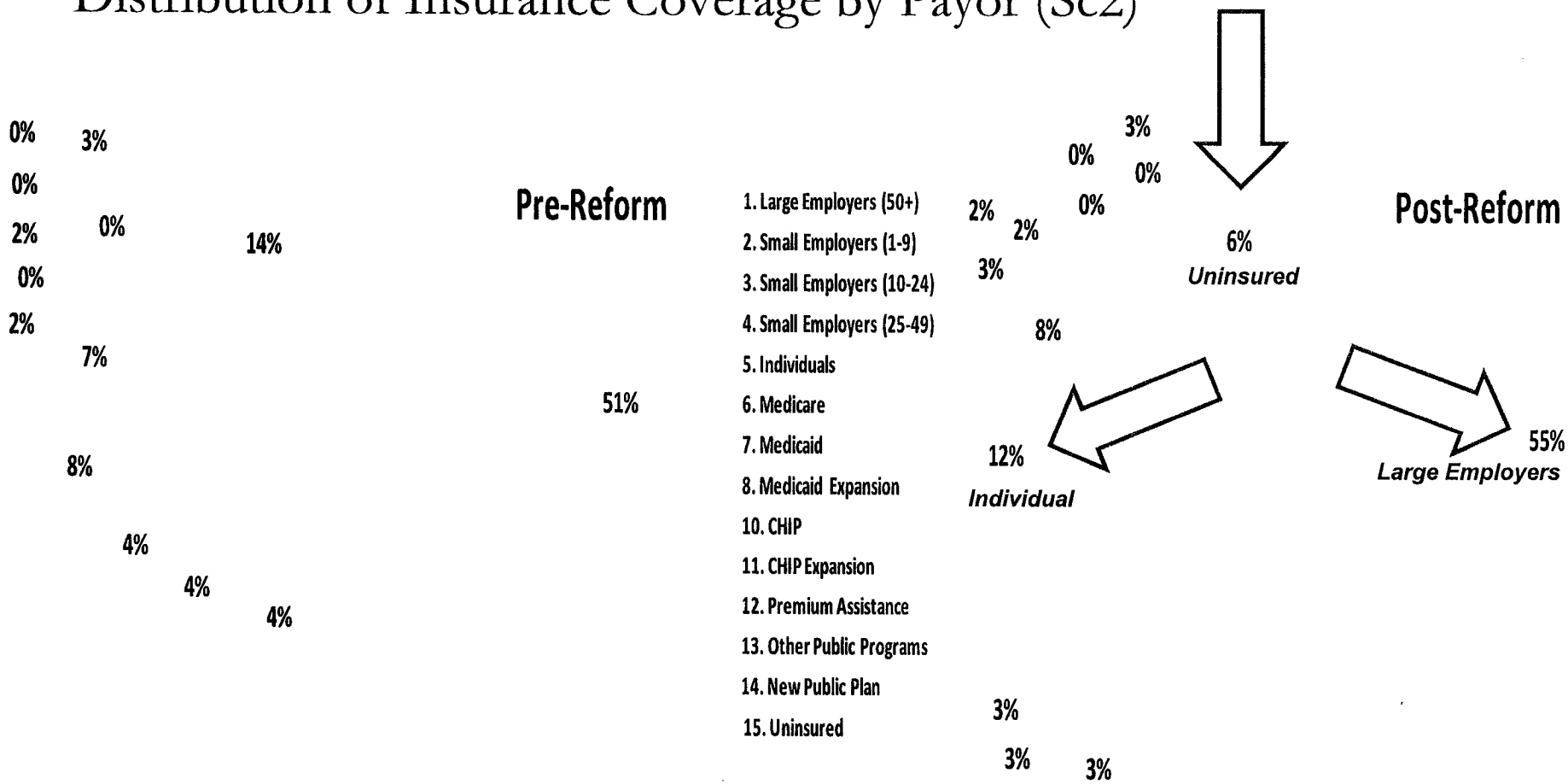
Kansas – Pre-FHCR vs. Post-FHCR

Distribution of Insurance Coverage by Payor (Sc2)



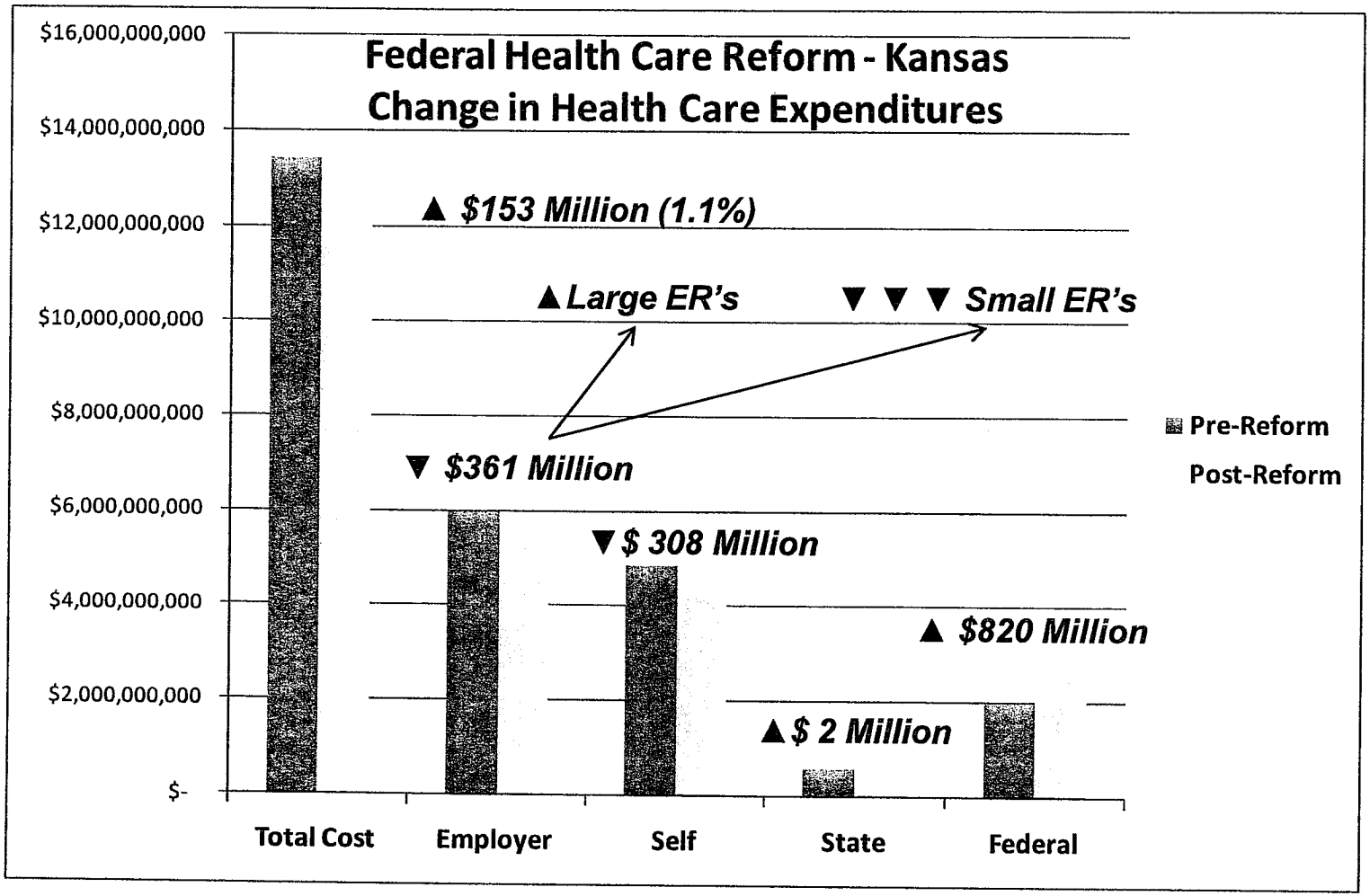
Kansas – Pre-FHCR vs. Post-FHCR

Distribution of Insurance Coverage by Payor (Sc2)



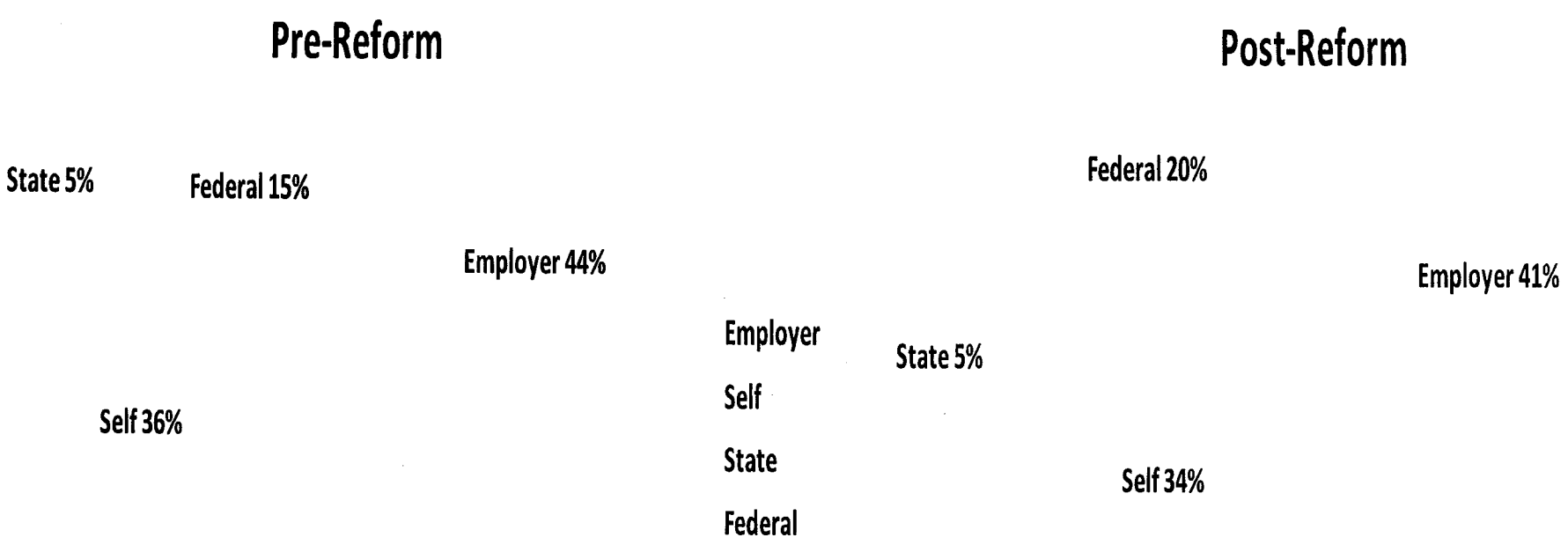
Kansas – Pre-FHCR vs. Post-FHCR

Health Care Expenditures by Payor (Sc2)



Kansas – Pre-FHCR vs. Post-FHCR

Health Care Expenditures by Payor (Sc2)



Questions

(b) TERMS RELATING TO HEALTH PLANS.—In this title:

(1) HEALTH PLAN.—

(A) IN GENERAL.—The term "health plan" means health insurance coverage and a group health plan.

(B) EXCEPTION FOR SELF-INSURED PLANS AND MEWAS.—Except to the extent specifically provided by this title, the term "health plan" shall not include a group health plan or multiple employer welfare arrangement to the extent the plan or arrangement is not subject to State insurance regulation under section 514 of the Employee Retirement Income Security Act of 1974.

(2) HEALTH INSURANCE COVERAGE AND ISSUER.—The terms "health insurance coverage" and "health insurance issuer" have the meanings given such terms by section 2791(b) of the Public Health Service Act.

(3) GROUP HEALTH PLAN.—The term "group health plan" has the meaning given such term by section 2791(a) of the Public Health Service Act.

SEC. 1302. [42 U.S.C. 18022] ESSENTIAL HEALTH BENEFITS REQUIREMENTS.

(a) ESSENTIAL HEALTH BENEFITS PACKAGE.—In this title, the term "essential health benefits package" means, with respect to any health plan, coverage that—

(1) provides for the essential health benefits defined by the Secretary under subsection (b);

(2) limits cost-sharing for such coverage in accordance with subsection (c); and

(3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

(b) ESSENTIAL HEALTH BENEFITS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

(A) Ambulatory patient services.

(B) Emergency services.

(C) Hospitalization.

(D) Maternity and newborn care.

(E) Mental health and substance use disorder services, including behavioral health treatment.

(F) Prescription drugs.

(G) Rehabilitative and habilitative services and devices.

(H) Laboratory services.

(I) Preventive and wellness services and chronic disease management.

(J) Pediatric services, including oral and vision care.

(2) LIMITATION.—

(A) IN GENERAL.—The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a

survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary.

(B) CERTIFICATION.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).

(3) NOTICE AND HEARING.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall provide notice and an opportunity for public comment.

(4) REQUIRED ELEMENTS FOR CONSIDERATION.—In defining the essential health benefits under paragraph (1), the Secretary shall—

(A) ensure that such essential health benefits reflect an appropriate balance among the categories described in such subsection, so that benefits are not unduly weighted toward any category;

(B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(E) provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that—

(i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

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(F) provide that if a plan described in section 1311(b)(2)(B)(ii) (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph (1)(J); and

(G) periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains—

(i) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;

(ii) an assessment of whether the essential health benefits needs to be modified or updated to account for changes in medical evidence or scientific advancement;

(iii) information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base;

(iv) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and

(H) periodically update the essential health benefits under paragraph (1) to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted under subparagraph (G).

(5) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection.

(c) REQUIREMENTS RELATING TO COST-SHARING.—

(1) ANNUAL LIMITATION ON COST-SHARING.—

(A) 2014.—The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014.

(B) 2015 AND LATER.—In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall—

(i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and

(ii) in the case of other coverage, twice the amount in effect under clause (i).

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Kansas Insurance Department
Sandy Praeger, Commissioner of Insurance

TESTIMONY ON
KHIA / PCIP - KS

JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT
November 4, 2010

Madam Chair and Members of the Committee:

The incidence of rejection or loss of health insurance coverage due to pre-existing medical conditions prompted the Kansas Legislature to create the Kansas Health Insurance Association ("KHIA") in 1992. KHIA's mission is to offer affordable comprehensive health insurance coverage to persons otherwise unable to gain coverage in the individual market because of pre-existing conditions. In keeping with this commitment, Kansas is one of 28 states to have elected to administer its own Pre-Existing Condition Insurance Plan ("PCIP - KS), as opposed to a federally run plan, under the Affordable Care Act. KHIA will administrate PCIP – KS, in addition to the state high risk pool plan. The following are summaries and descriptions of both plans, intended for educational purposes. The section on PCIP – KS includes little numerical data due to its brief existence.

STATE HIGH-RISK POOL PLAN

KHIA offers a state plan to provide health care benefits for Kansas residents who are unable to purchase health insurance or obtain coverage due to a pre-existing medical condition, who have exhausted their health insurance benefits, who have been quoted insurance rates more than the KHIA rate, or who otherwise qualify under the Health Insurance Portability and Accountability Act (HIPAA). Kansas is one of 35 states that have established a high risk pool to assist people with pre-existing conditions. KHIA had 1,752 primary policyholders at the end of 2009.

For an individual to qualify for KHIA coverage, he or she must provide proof of the following:

- Kansas residency for six months prior to application; and
- Ineligibility for Medicare and Medicaid; and
- Rejection of application for insurance by two carriers because of a health condition; or
- Insurance quoted at a rate higher than the KHIA rate; or
- Acceptance for health insurance subject to an exclusion of a pre-existing disease or condition; or
- Previous individual insurance coverage involuntarily terminated for a reason other than non-payment of premiums.

420 SW 9th Street
Topeka, Kansas 66612-1678
785-296-3071 Phone
785-296-2283 Fax
Consumer Hc
800-432-2

Applicants are subject to a 90-day pre-existing condition exclusion, if there is a lapse in coverage, or absence of coverage, of more than 31 days prior to enrollment in KHIA. These requirements, and the documentation required to prove eligibility, are described in more detail on the KHIA website at www.khiastatepool.com/qualify.asp.

KHIA provides a lifetime benefit of $2 million. Current KHIA plan deductibles include $1,500, $2,500, $5,000, and $10,000. In 2009, KHIA enrollees' premiums (set annually) were approximately 128% of the average premiums of the state's largest insurers. This is toward the low end of the range for federally-qualified pools. The Kansas statutory limit is 150%. KHIA policies are rated by age, gender and smoking status. The KHIA Board of Directors establishes premium changes, and the Insurance Commissioner approves them.

The following are notable statistics regarding KHIA claims:

- Claims incurred by KHIA in 2009 were $24,068,791 – up $2,361,856 from 2008, and $5,803,906 from 2007.
- Claims incurred on a per-member-per-month ("PMPM") basis were $1,104.48 in 2009 – compared to $963.72 in 2008, and $805.33 in 2007.
- Claims of $30,000 or more accounted for 12% of claims made, and for 72% of claims dollars in 2009.
- Claims of $100,000 or more accounted for 2% of claims made, and 34% of claims dollars in 2009.
- Claims for outpatient services account for 34% of all services.
- Claims for inpatient services account for 33% of all services.

Total combined spending for KHIA and it members totaled $41,870,714 in 2009. KHIA's expenses equaled 57% or $24,068,791 of this figure. KHIA members incurred the rest of the expenses, 30% in premiums and 17% out-of-pocket. The $24,608,791 shortfall to KHIA is financed in part by insurer assessments and federal grants.

Since KHIA's inception, $82 million has been assessed against the state's insurers to help cover the losses incurred by enrollees. Theses assessments totaled $15 million in 2007, $10.385 million in 2008, and $11 million in 2009.

KHIA received $8,575,490 in available federal funds from 2003 to 2009, with $1,667,228 available for 2009. Federal grant funds to KHIA have steadily increased in recent years. KHIA has used these funds to cap co-payments for generic prescriptions, preventative services, case management, a premium holiday in 2005, executive director compensation, and residuals for claims payments. Funds received are based on a weighted formula that considers the percentage of uninsured, enrollment, and population size.

The demographics of KHIA membership vary by age and gender. Overall, enrollees are 56% females and 44% males. One-third of enrollees are 60 to 64 years of age, while only 5% are under age 20. In recent years, the relative number of males and younger individuals joining KHIA has increased.

PCIP - KS

PCIP - KS is a federally-funded insurance program that provides health insurance for Kansans who have been uninsured due to a pre-existing condition. The program is entirely supported by federal funds. It is intended to provide coverage for uninsured individuals with pre-existing conditions until the healthcare exchanges contemplated under the Affordable Care Act become operable in January 2014. PCIP – KS will phase out at that time.

KHIA is the plan administrator of PCIP – KS. The U.S. Department of Health and Human Services is the contract holder. PCIP – KS offers an extensive provider network throughout Kansas that includes a wide network of doctors, hospitals, and other healthcare service providers.

To qualify for PCIP - KS coverage, an individual must meet the following criteria:

- be a U.S. citizen or national, or person lawfully present in the United States; and
- be a resident of Kansas; and
- have been uninsured for at least six months prior to applying; and
- have a qualifying pre-existing medical condition.

KHIA will accept as proof of a pre-existing condition a denial letter from an insurance company for a qualifying pre-existing condition, or a letter of acceptance with a reduction or exclusion of coverage for a qualifying pre-existing condition.

As a result of the second requirement, an individual cannot participate in PCIP – KS, if he or she is currently covered under KHIA's state high risk pool plan, a COBRA plan, or any other health insurance plan. In fact, any such coverage must have expired for at least six months before the individual can qualify for PCIP – KS.

Under PCIP – KS, covered individuals must pay a deductible of $2,500, with an annual out-of-pocket limit of $5,950. Premiums are based on: (1) where the individual lives; (2) the individual's age; and (3) whether the individual uses tobacco. All PCIP – KS contracts are annually renewable.

During August, September, and October 2010, KHIA received 113 applications for PCIP – KS coverage. At the end of October, there were 29 pended applications and 83 enrollees. However, it is estimated that of the 347,000 uninsured Kansas as of December 2009, 43,722 would have been eligible for the PCIP - KS plan.

If you meet the eligibility requirements and have one of the following diseases, you are automatically eligible for the PCIP-KS plan:

- Acquired Immune Deficiency Syndrome *(AIDS)*
- Alzheimers
- Angina Pectoris
- Anorexia Nervosa
- Arteriosclerosis Obliterans
- Artificial Heart Valve
- Ascites
- Brain Tumors
- Cardiomyopathy
- Cerebral Palsy
- Chronic Pancreatitis
- Cirrhosis of the Liver
- Coronary Insufficiency
- Coronary Occlusion
- Crohn's Disease
- Cystic Fibrosis
- Dermatomyositis
- Diabetes
- Epilepsy
- Friedreichs's Disease
- Heart Disorders
- Hemophilia
- Hepatitis C *(Active)*
- HIV+
- Hodgkin's Disease
- Huntington's Chorea
- Hydrocephalus
- Intermittent Claudication
- Kidney Failure
- Lead Poisoning *with Cerebral Involvement*
- Leukemia
- Lupus
- [redacted]gnant Tumor *(if [redacted]ted or has occurred within last four years)*
- Mental Retardation
- Metastatic Cancer
- Motor or Sensory Aphasia
- Multiple or Disseminated Sclerosis
- Muscular Atrophy or Dystrophy
- Myasthenia Gravis
- Myotonia
- Obesity - Morbid
- Open Heart Surgery
- Paraplegia or Quadriplegia
- Parkinson's Disease
- Peripheral Arteriosclerosis *(if treatment within last three years)*
- Poliomyelitis
- Polycystic Kidney
- Polyarteritis *(periarteritis-nodosa)*
- Postero-lateral Sclerosis
- Pregnancy
- Psychotic Disorders
- Rheumatoid Arthritis
- Sickle Cell Anemia
- Silicosis
- Splenic Anemia *(True Banti's Syndrome)*
- Still's Disease
- Stroke *(CVA)*
- Syringomyelia
- Tabes Dorsalis *(locomotor ataxia)*
- Thalassemia *(Cooley's or Mediterranean Anemia)*
- Topectomy and Lobotomy
- Ulcerative Colitis
- Wilson's Disease

Kansas Insurance Department

Contact us:

Online:
www.ksinsurance.org

By e-mail:
commissioner@ksinsurance.org

Consumer Assistance Hotline:
800-432-2484

Main Number:
785-296-3071

By mail:
420 SW 9th St., Topeka, KS 66612

By fax:
785-296-7805

Hours:
8 a.m. to 5 p.m. weekdays
(except state holidays)

Sandy Praeger,

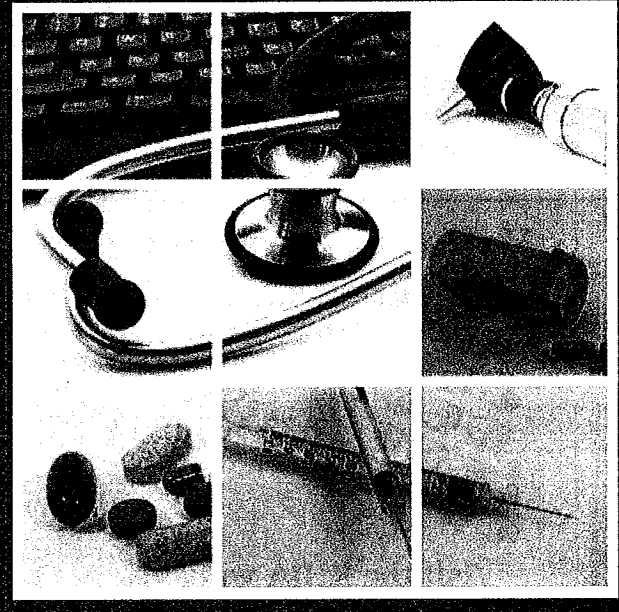
Commissioner of Insurance

11-4
#5

November 2010

Pre-existing Condition Insurance Plan - Kansas

(PCIP - KS)



A publication of the Kansas Insurance Department

JOINT COMMITTEE ON HEALTH
POLICY OVERSIGHT
DATE: 11-4-10
ATTACHMENT: 5

Who is Eligible?

*In order to be eligible for the PCIP-KS plan, you must fulfill **all** of the following:*

•Be a citizen or legal resident of the United States.

•Be a resident of Kansas.

•Have been uninsured for at least 6 months prior to applying for coverage.

•Have a pre-existing condition. (A denial letter from an insurance company or a letter of acceptance with a reduction or exclusion of coverage because of your pre-existing condition are both acceptable forms of proof).

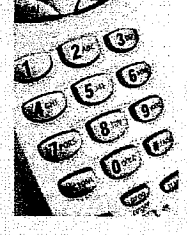
What does the plan include?

•Deductible of $2,500/year

•Out-of-pocket Limit: $5,950/year

•Premium is calculated based on:
- Where you live
- How old you are
- Whether or not you use tobacco

How do I enroll in this coverage?



Call:
877-505-0511

Visit the KHIA website:

www.khiastatepool.com
and click on the link under "Pre-existing Condition Insurance Plan - KS (PCIP - KS)

Frequently Asked Questions*

Q: I am currently enrolled in KHIA's Kansas High Risk Pool. Can I transfer my coverage to the PCIP-KS plan?

A: No. If you have KHIA's plan, you have insurance and won't qualify for PCIP-KS. Officials do not recommend that anyone deliberately drop insurance in the hope of joining PCIP-KS.

Q: What is a pre-existing condition?

A: A pre-existing condition is a health condition, disability, or illness (either physical or mental) that has prevented you from obtaining health insurance (see Covered Conditions).

Q: May I apply for PCIP-KS if I have COBRA or other continuation coverage?

A: No, even if your COBRA or other continuation of coverage is about to run out, you won't meet the requirement to be uninsured for at least six months. You also need to meet the criteria for having a pre-existing condition and be a resident of Kansas to qualify for the PCIP-KS.

Q: Can I enroll my entire family in this coverage?

A: No. This coverage is for individuals only. Children may be accepted into the PCIP - KS plan, but must meet the same eligibility requirements as adults.

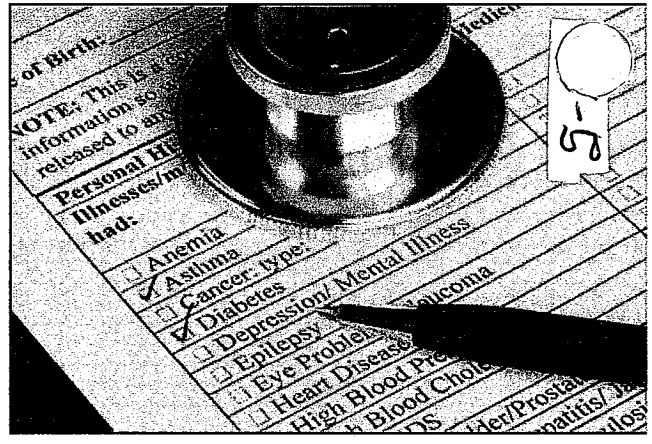
Q: How much will this coverage cost?

A: Premiums will vary based on a person's age, where she or he lives and tobacco use. Call 1-877-505-0511 for a rate quote specific to you.

Q: What health care providers are in the network?

The PCIP-KS Plan has an extensive provider network throughout Kansas that includes a wide range of doctors, hospitals and other health care service providers.

FAQs adapted from www.healthcare.gov and the IPXP in Illinois.



Q: What do I do if I can't afford these premiums?

A: If you have limited income and resources (assets), you may be eligible for the Medicaid program. If you are seeking insurance coverage for your child, go to www.insurekidsnow.gov to learn more about health insurance in Kansas.

Q: Where can I find the application to enroll in the PCIP-KS plan?

A: The application for the PCIP-KS plan can be accessed by visiting www.khiastatepool.com. Click under "Pre-existing Condition Insurance Plan-KS (PCIP-KS)", and then download the .pdf version of the application. You can also call 877-505-0511 for more information.

Q: If I'm accepted into the PCIP-KS, can I keep that coverage?

A: Yes, but only until 2014. The plan will phase out at that time, and the state will start a new health insurance Exchange offering coverage to everyone who's uninsured. Lower-income Kansans will get subsidies, and members of PCIP-KS will be able to join the exchange, just like everyone else.

Brochure paid for by federal funds authorized by the Affordable Care Act.

2009 ANNUAL REPORT

KANSAS HEALTH INSURANCE ASSOCIATION

PROFILE AND OPERATING RESULTS

OF THE KANSAS HIGH RISK HEALTH INSURANCE POOL

5-3

LETTER FROM THE CHAIRMAN

William Tracy
Chairman, Kansas Health Insurance Association
Overland Park, Kansas
www.khiastatepool.com

This annual report of the Kansas Health Insurance Association is being published at a tumultuous time in our healthcare history. The expression 'change is a constant' seems more timely than ever. All quarters of health insurance and caregiving will be affected in coming years by scarce resources, altered reimbursement and eligibility, and possibly increased demands all while adapting to new technologies, treatments, and organizational forms.

The first edition of our annual report for the Kansas Health Insurance Association is intended to provide you with additional insight into the operations of a state high risk pool. It has been prepared with a wide audience in mind. As you examine the results and statistics presented here, you'll come to appreciate the special role that a state high risk pool plays in protecting the health of many Kansans. The Insurance Department, all of the state's health insurers, and public members represented on our Board of Directors remain committed to providing the best possible comprehensive insurance coverage and access to quality health services for our enrollees.

Special thanks are extended to the Kansas Insurance Department for its guidance and counsel through the years, as well as to our supporting resources (Benefit Management Inc., Miller and Newberg Consulting Actuaries, Medco Health Solutions, and OptumHealth) for facilitating effective operations and case management services.

Sincerely,

William Tracy

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2009 ANNUAL REPORT
KANSAS HEALTH INSURANCE ASSOCIATION

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Within the parameters outlined in state law, the KHIA Board establishes appropriate rates for policy holders, adjusts these rates annually, assesses insurers in Kansas, pays agents' referral fees, maintains appropriate claims reserves, invests and manages funds, designs policies with appropriate limitations and benefit levels, issues policies of insurance, and incurs administrative expenses to manage its work.

Service Units and Vendors. KHIA is a small and complex organization with services spanning eligibility verification, premium billing (e.g., collections, lockbox deposits, and terminations), banking, claims payment, utilization review, case management, reporting, audit, actuarial support, assessments, customer service, web-based services, and pharmacy benefits administration. KHIA is responsible for administering the state's Medicare Supplement Reinsurance Program. KHIA contracts with two preferred provider organizations (PPO networks), a third party administrator, pharmacy benefits administrator, case management firm, certified public accountant, a banking entity, and a consulting actuary to fulfill its business obligations.

Plans and Benefits. KHIA plan deductibles that are currently open to enrollees include $1,500, $2,500, $5,000, and $10,000. There is a six-month waiting period for pre-existing conditions. Coverage for inpatient hospital care, durable medical equipment, and home health must be reviewed and approved by KHIA's case manager. In-network provider discounts are offered by two PPO networks. Individuals waiting for organ transplantation or recent recipients receive counseling and guidance on centers of excellence. There is a $2 million lifetime benefit.

Eligibility. Coverage requires proof of 6-months Kansas residency, ineligibility for Medicare or Medicaid, and involuntary termination of health insurance coverage for reasons other than nonpayment of premiums. Evidence must be provided that the applicant was rejected by two health insurance carriers because of health conditions, quoted a premium rate that exceeded the Plan rate *or* was accepted for coverage subject to a permanent exclusion of a pre-existing disease or medical condition. Federally Defined Eligible Individuals who are Kansas residents with aggregate creditable coverage of 18+ months under a government, group, church or similar plan with exhausted COBRA coverage are also eligible.

Financial Issues. Enrollees' premiums, set annually, were approximately 128% of the average of the state's largest insurers in 2009. This is favorably at the low end of the range for federally-qualified pools. The Kansas statutory limit is 150%. The policies are rated by age in single years, gender, and smoking status. Changes in premiums are approved by the Insurance Commissioner and established by the Board of Directors based on a state market basket of changes in individual policies. KHIA premium increases were 14% in 2003, 8% in 2004, 3% in 2005, 2.5% in 2006, 3.8% in 2007, 13.8% in 2008, 9% in 2009, and 13.35% in 2010. The Board of Directors strives to keep these increases low.

Medical Loss Ratios. Overall medical spending for KHIA enrollees consistently exceeds total premiums paid. The total loss ratio for KHIA from 2004 through 2009 was 174%. This means there is $174 in claim expense for every $100 in premium income. KHIA ended 2009 with a loss ratio of 197%. Two low deductible plans had loss ratios well over 225% in 2009 and one reached 328%. Covering plan losses required KHIA to assess insurers $15 million in 2007, $10.385 million in 2008, and $11 million in 2009. Assessments are based on the proportion of carriers' annual health insurance premiums. Since KHIA's inception, over $82 million has been paid by insurers.

Incurred Claims. There was $24,068,791 in incurred claims for 2009 compared with $**$21,706,935**for 2008. Comparable totals for prior years are **$18,264,831**for 2007 and $18,782,387 for 2006. On a per-member-per-month (PMPM) basis, 2009 incurred claims were $1,086 for 2009 compared with $961 for 2008 (+13%). Claims over $30,000 accounted for 12% of the claims count and 72% of all claims dollars. It isn't uncommon for a large claim to top $500,000 and for a large pharmacy claim to reach $75,000. The size and frequency of large claims has been increasing steadily in recent years.

Federal Grant Funds. KHIA had $1,485,624 of federal funding available for 2009. KHIA received $1,461,689 in 2004, $1,297,042 in 2005, and $1,031,608 in 2006 plus $295,000 for disease management planning. Funds have been applied to cap co-payments for generic prescription drugs, preventive services, case management, a premium holiday in 2005, executive director compensation, and residuals for claims payments. The amount a state receives is based on a weighted formula of the percent uninsured, enrollment, and population size.

Cost Management. KHIA's challenge is to ensure that enrollees receive well-coordinated, quality health services resulting in positive health outcomes. Effective care management is critical to maintaining the pool's financial viability and affordability for current and future enrollees. KHIA contracts with a nationally-regarded firm specializing in utilization review, pre-authorization, and case management functions to improve outcomes while preserving resources. The Operations Committee has focused on enhancing enrollee communications, creating incentives for health promotion, and implementing a web site for health risk appraisals and wellness interventions.

Funding Sources. Nationally, there are about 178,000 high risk pool policy holders. It is estimated that less than two percent of the U.S. population receives coverage through these dedicated pools. Premiums that range from 125 percent to 200 percent of the market average limit enrollment. However, premiums typically cover only about half of claims costs and administrative expenses. In Kansas, the shortfall is financed by assessing insurance companies and federal grants.

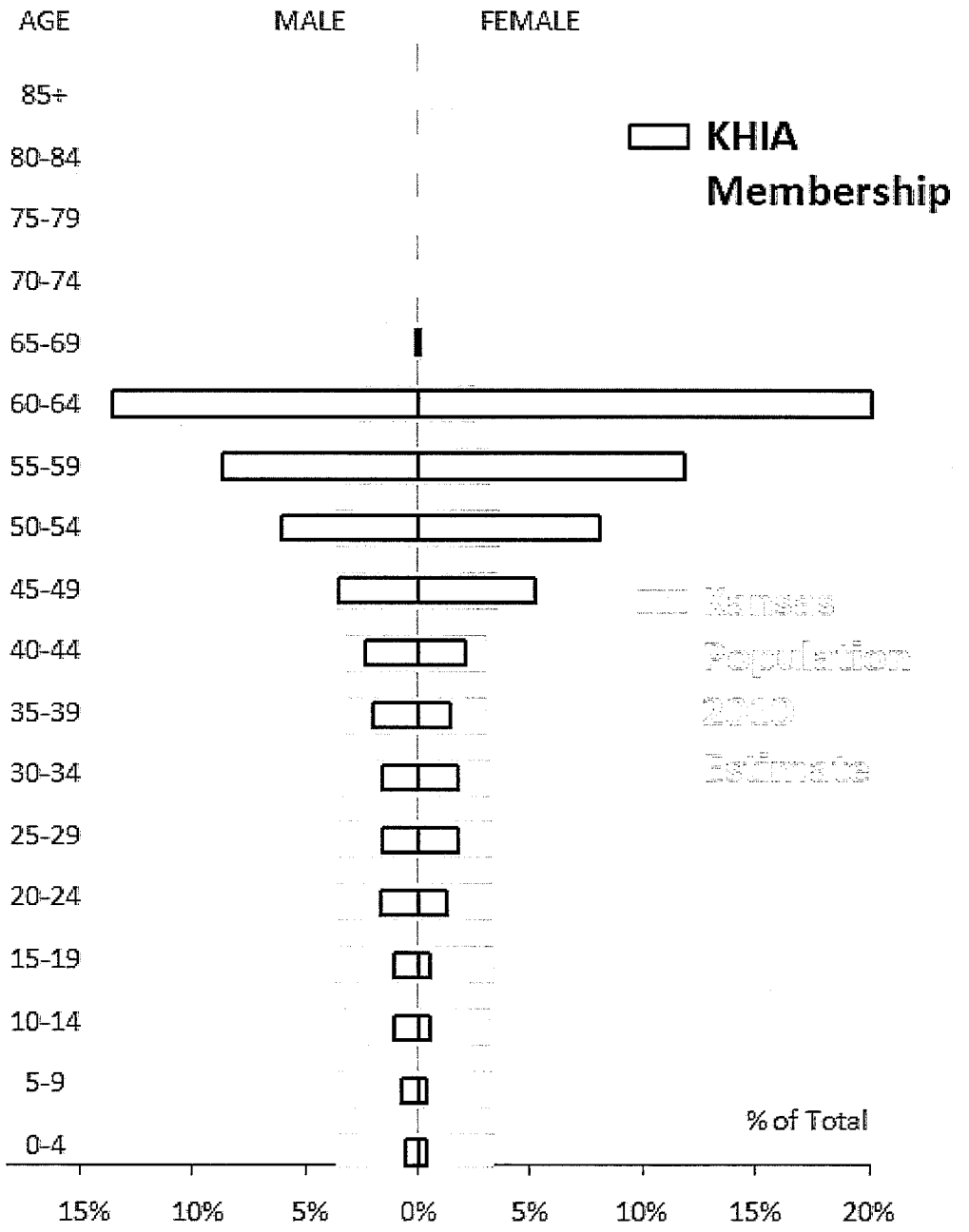
References / Contacts. The NASCHIP publishes an annual report on high risk pools entitled *Comprehensive Health Insurance for High-Risk Individuals.* A copy can be ordered at www.naschip.org. KHIA's website is www.KHIAstatepool.com. Contact the

plan's third party administrator, Benefit Management, Inc. at 800-290-1368 or www.benefitmanagementks.com.

AGE AND GENDER

An illustration of the percent distribution of KHIA enrollees by gender and age is presented in Chart 1. Overall, 56% are females and 44% males. One-third of enrollees are between the ages of 60 to 64 years while only 5% are under age 20. In recent years, proportionally more males and younger individuals have joined KHIA.

Chart 1. Percent Distribution of KHIA Enrollees by Age and Gender, 2009



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LENGTH OF TIME IN PLAN

Over 70% of KHIA enrollees have been in the plan less than 5 years (Table 1) and 25% for 12 months or less. There are 75 policyholders who have been enrolled for 10 or more years and 11 since its inception.

Table 1. KHIA Enrollment by Primary Policyholder, 2006 to 2009

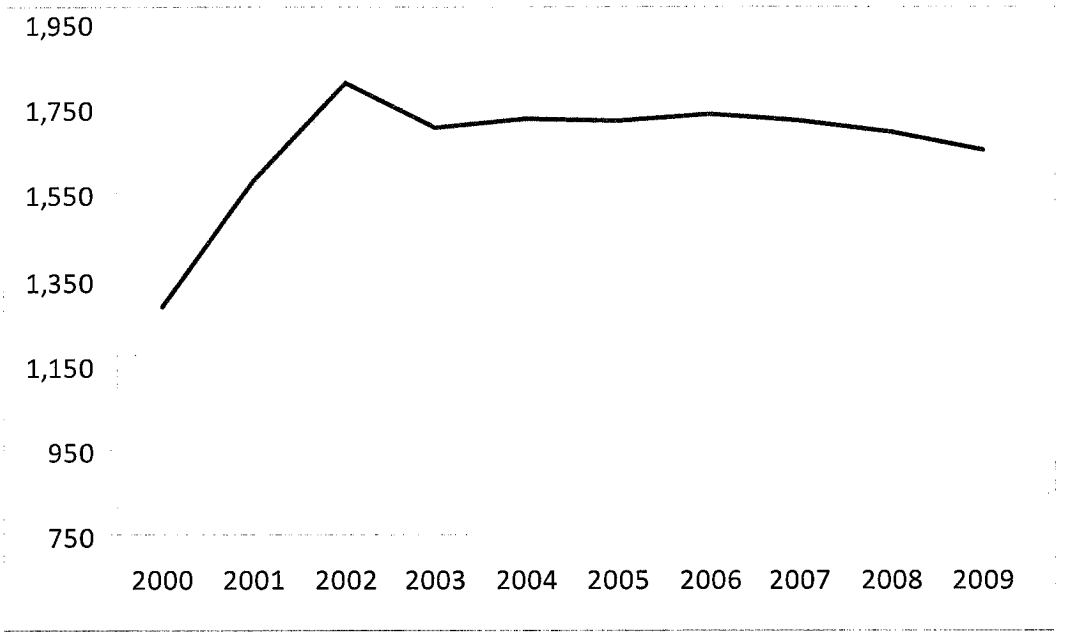
Years in Pool	2006	2007	2008	2009
Total	1,733	1,720	1,693	1,652
Under 1 year	459	439	439	428
1 year	300	298	284	290
2 years	252	206	209	202
3 years	136	200	153	155
4 years	214	109	159	106
5 years	146	170	79	121
6 years	77	118	134	63
7 years	34	62	90	105
8 years	37	27	49	69
9 years	20	27	21	38
10 years	22	17	19	17
11 years	12	16	15	14
12 years	14	11	15	13
13 years	10	11	10	14
14 years	0	9	10	6
15 years	0	0	7	6
16 years	0	0	0	5

Years in Pool	2006	2007	2008	2009
Total	100%	100%	100%	100.0%
Under 1 year	26.6%	25.6%	25.9%	25.9%
1 year	17.3%	17.3%	16.9%	17.6%
2 years	14.5%	12.0%	12.3%	12.2%
3 years	7.8%	11.6%	9.0%	9.4%
4 years	12.3%	6.3%	9.4%	6.4%
5 years	8.4%	9.9%	4.7%	7.3%
6 years	4.4%	6.9%	7.9%	3.8%
7 years	2.0%	3.6%	5.3%	6.4%
8 years	2.1%	1.6%	2.9%	4.2%
9 years	1.2%	1.6%	1.2%	2.3%
10 years	1.3%	1.0%	1.1%	1.0%
11 years	0.7%	0.9%	0.9%	0.8%
12 years	0.8%	0.6%	0.9%	0.8%
13 years	0.6%	0.6%	0.6%	0.8%
14 years	0.0%	0.5%	0.6%	0.4%
15 years	0.0%	0.0%	0.4%	0.4%
16 years	0.0%	0.0%	0.0%	0.3%

ENROLLMENT SUMMARY

The number of KHIA'S primary policyholders at the end of 2009 was 1,752 (Chart 2). The Board of Directors voted to offer individual-only policies beginning in 2009. Enrollment in recent years has been flat to declining.

Chart 2. Total Enrollment by Year, 2000 to 2009



The $2,500 deductible plan has become the most popular in recent years, followed by the $1,500 deductible and $5,000 deductible plans (Table 2). Since KHIA began offering a $10,000 deductible plan in 2007, 162 enrollees (9.2%) have selected this option.

Table 2. Total Enrollment by Deductible, 2006 to 2009

Deductible	2006	2007	2008	2009
$500	100	87	56	34
$1,000	325	287	176	94
$1,500	412	436	468	451
$2,500	164	189	359	477
$5,000	508	479	447	402
$7,500	394	336	217	132
$10,000	0	80	140	162

Deductible	2006	2007	2008	2009
$500	5.3%	4.6%	3.0%	1.9%
$1,000	17.1%	15.2%	9.4%	5.4%
$1,500	21.7%	23.0%	25.1%	25.7%
$2,500	8.6%	10.0%	19.3%	27.2%
$5,000	26.7%	25.3%	24.0%	22.9%
$7,500	20.7%	17.7%	11.6%	7.5%
$10,000	0.0%	4.2%	7.5%	9.2%

CLAIMS PAYMENT BY PLACE OF SERVICE

Total incurred claims for 2009 was $24,068,791. Two-thirds of this amount was incurred from inpatient and outpatient care (Chart 3). Doctor's office visits and prescription drug spending each amounted to about 12% of the total. In recent years, spending for outpatient care has risen dramatically, while hospice care has dropped (Table 3). Incurred claims costs for emergency room visits and ambulatory surgery have been relatively flat. The $1,722,380 home health expense in 2008 was mostly due to one large claim.

Chart 3. Incurred Claims by Place of Service, 2009

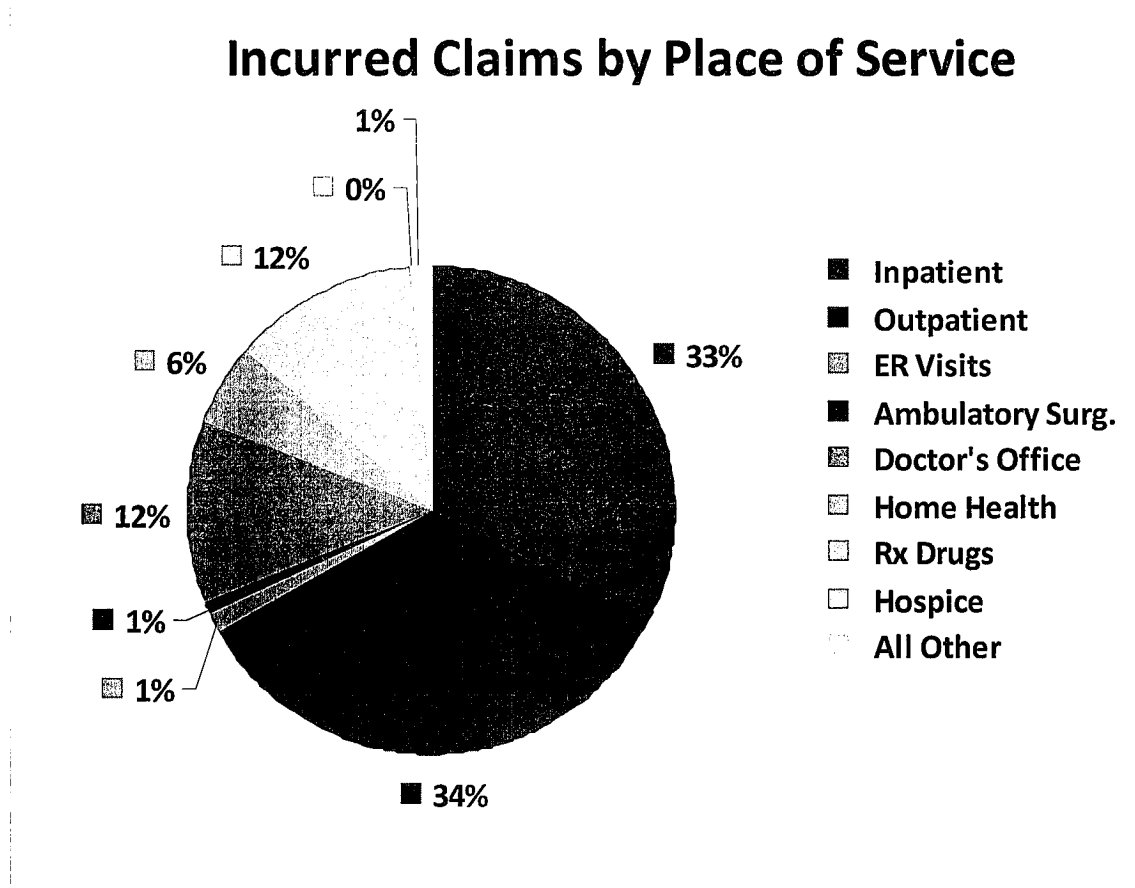


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Table 3. Incurred Claims by Place of Service, 2005 to 2009

Service	2005	2006	2007	2008	2009
Total	$15,404,345	$18,782,387	$18,264,831	$21,706,935	$24,068,791
Inpatient	$5,124,207	$8,057,903	$6,447,431	$7,266,386	$7,830,173
Outpatient	$4,377,723	$4,520,782	$4,539,053	$6,456,367	$8,218,518
ER Visits	$313,606	$286,360	$261,242	$277,473	$322,949
Ambulatory Surgery	$180,778	$177,408	$185,093	$231,662	$207,637
Doctor's Office	$1,985,570	$2,278,466	$2,603,516	$2,581,872	$2,881,884
Home Health	$919,673	$690,887	$923,471	$1,722,380	$1,337,976
Drugs	$2,251,794	$2,513,057	$3,046,745	$2,908,328	$2,947,997
Hospice	$46,609	$35,603	$14,539	$27,376	$6,961
All Other	$204,384	$221,921	$243,741	$235,092	$314,697

Chart 4. Incurred Claims: Total, Inpatient, Outpatient, and Prescription Drugs, 2005 to 2009

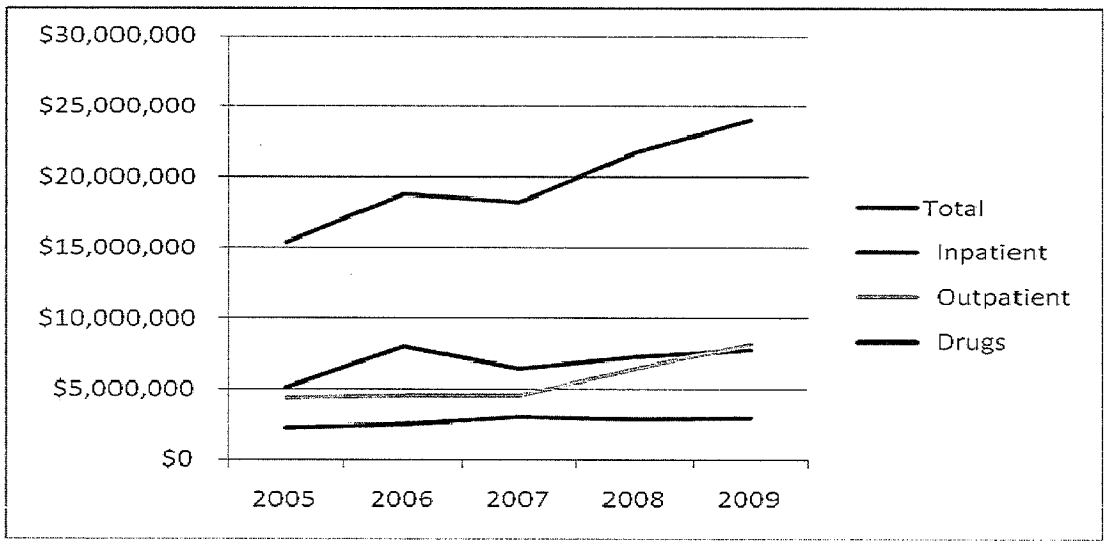

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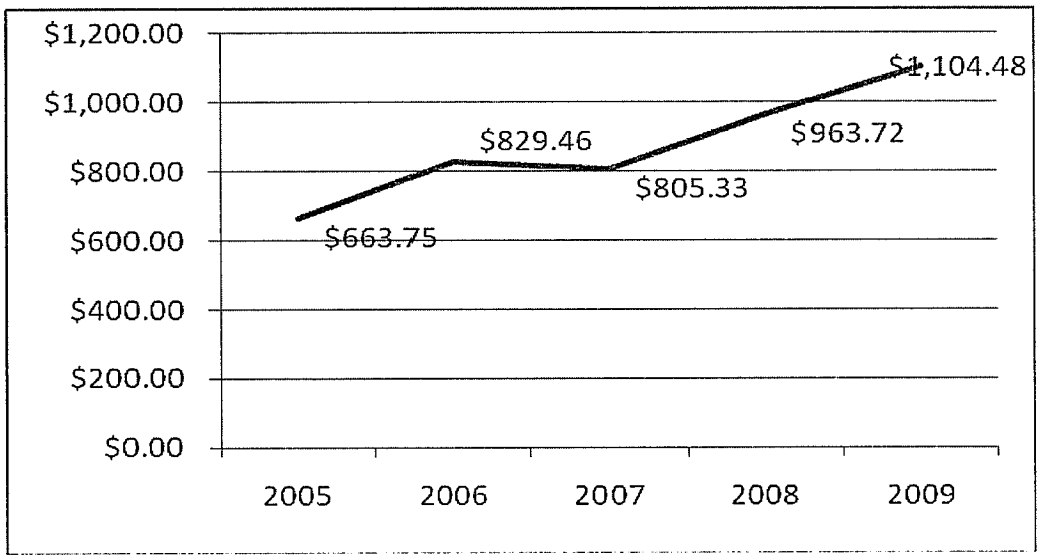
Chart 5. Incurred Claims Per Member Per Month, 2005 to 2009



Trending incurred claims from 2005 to 2009 shows significant increases in both percentages and dollars spent (not adjusted for inflation). Total spending has increased 156% from $15,404,345 in 2005 to $24,068,791 at the end of 2009. This represents an increase of $8,664,446 over the period. The greatest dollar and percent increases have been in outpatient services (+188%) and inpatient services (+153%). Ironically, given the severity of illness in this population, hospice costs have decreased from $46,609 in 2005 to $6,961 in 2009 (an 85% decrease).

INPATIENT, OUTPATIENT AND EMERGENCY ROOM UTILIZATION

Per member per month (PMPM) spending for inpatient services was 11.7% higher in 2009 compared with 2008 (Table 4). PMPM expenses were $359.81 in 2009 versus $322.16 in 2008. Total inpatient spending for the most recent 12-month period was $7,830,173 compared with $7,266,386 in the prior period.

Table 4. Spending on Inpatient Services, 2009

Service	Claims Costs	PMPM	Claimants	Admits	Average LOS*	% Change
Inpatient	$7,830,173	$359.81	195	274	6.4	11.7%
ICU/CCU	$506,251	$23.26	59	74	5.8	5.3%
All Other	$7,323,923	$336.55	---	---	---	12.2%

* Length of Stay

Claims costs for all outpatient services nearly reached $10 million in 2009 (Table 5). This represents an increase of over 21% from 2008. Most of the increase was for outpatient visits (+31.9%). Visits to the emergency room increased by over 20%, while home health expenses declined by nearly 20%.

Table 5. Spending on Outpatient Services, 2009

	Recent 12-Months (1/09 - 12/09)			Previous 12-Months (1/08 - 12/08)			% Change
Service	Claims Costs	Claims	PMPM	Claims Costs	Claims	PMPM	PMPM
Total Outpatient	$9,879,444	--	453.98	$8,456,219	--	374.92	21.1%
ER Visits	322,949	759	14.84	277,473	735	12.30	20.6%
Outpatient Hospital	8,218,518	8,536	377.65	6,456,367	7,876	286.25	31.9%
Home Health	1,337,976	348	61.48	1,722,380	337	76.36	-19.5%

MEDICAL CLAIMS BY SIZE

The percent distribution of the number of claims paid in 2009 (Chart 6) is inversely related to the percent distribution of the size of claims in dollars (Chart 7). For example, 12% of all paid claims in 2009 were for amounts exceeding $30,000. The dollar value of these claims represented 72% of all paid claims during the period. Similarly, claims over $100,000 represented 1% of all claims, but 34% of dollars spent. The number and amount of large claims has been steadily increasing in recent years. Chart 8 illustrates the importance of these claims in relation to total spending.

Chart 6. Percentage Distribution of Claims Count by Size, 2009

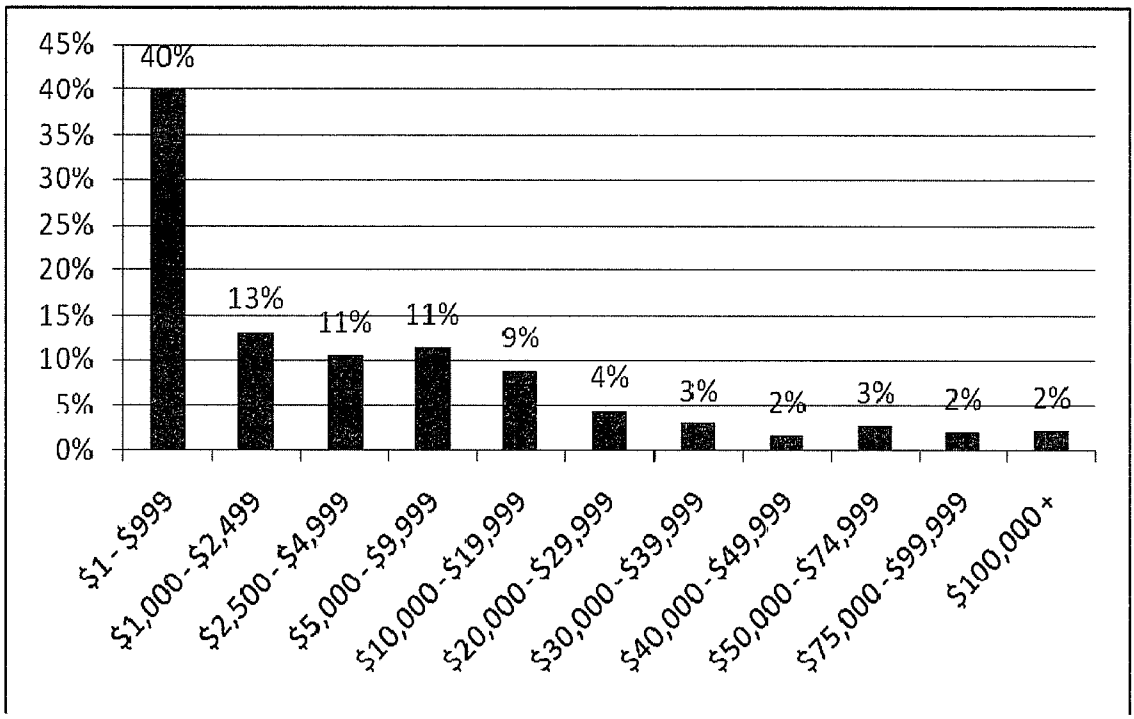


Chart 7. Percentage Distribution of Claims Dollars by Size, 2009

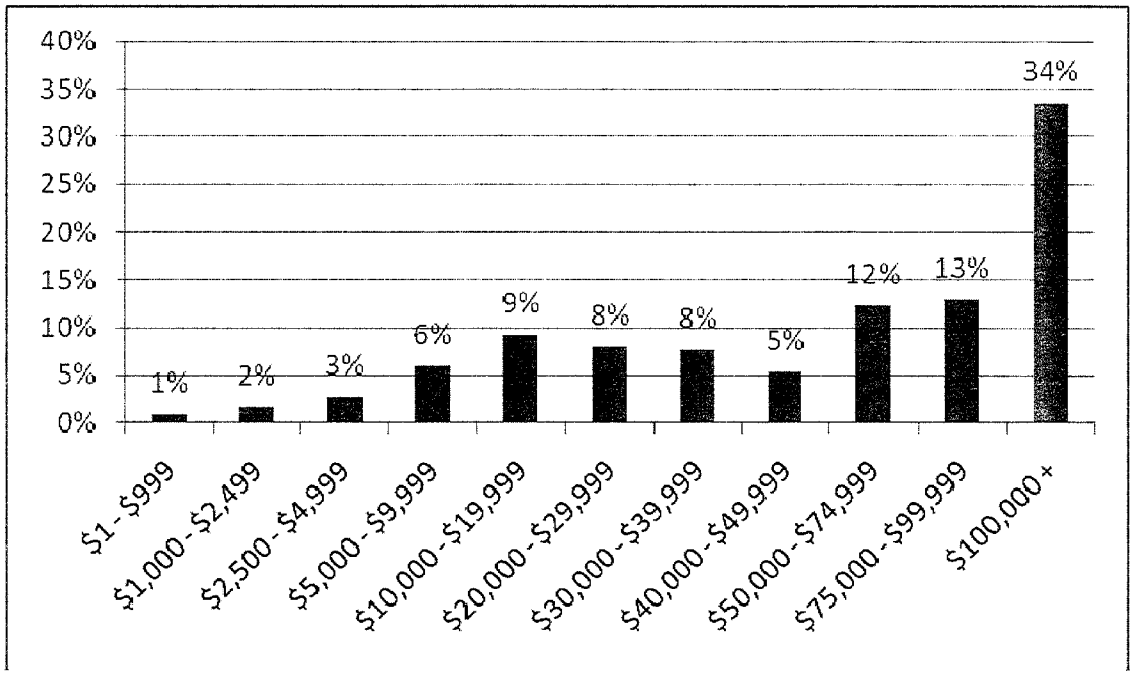
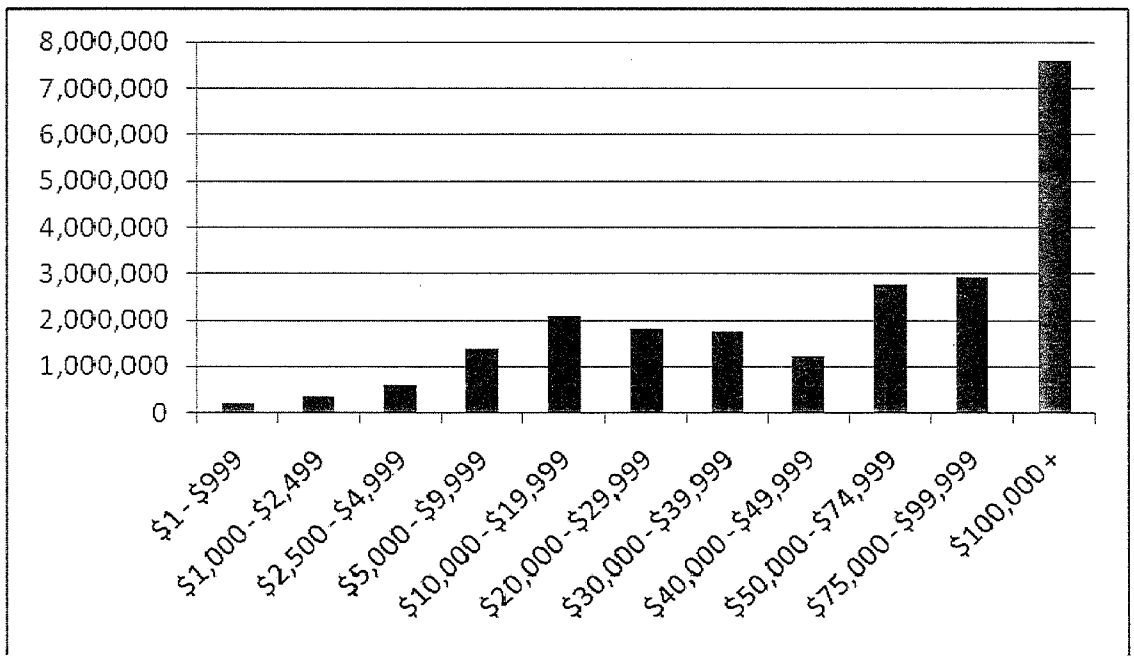


Chart 8. Claims Dollars by Size, 2009



The 10 largest claims for 2009 are listed in Table 6. They are responsible for 17.3% of total 2009 spending. The largest claim was for $1,129,862. Cancer and genitourinary system disorders are responsible for 4 of the 10 largest claims.

Table 6. Ten Largest Paid Claims, 2009

Rank	Total Paid	Major Diagnosis #1	Major Diagnosis #2	Plan Deduct	% of Total
1	1,129,862	Lymphatic Cancer (48%)	Cancer, unspecified (26%)	$2,500	5.0%
2	447,916	Genitourinary system (78%)	Injury/poisoning (11%)	$1,500	2.0%
3	423,637	Infections (51%)	Respiratory (13%)	$1,500	1.9%
4	412,024	Genitourinary system (85%)	Digestive (6%)	$2,500	1.8%
5	313,524	Congenital (70%)	Injury/poisoning (24%)	$2,500	1.4%
6	286,849	Genitourinary system (77%)	Digestive (16%)	$1,500	1.3%
7	255,835	Congenital (38%)	Injury/poisoning (25%)	$1,500	1.1%
8	221,518	Aftercare (45%)	Lymphatic Cancer (44%)	$1,500	1.0%
9	220,092	Nervous (35%)	Injury/poisoning (21%)	$2,500	1.0%
10	219,283	Digestive Cancer (74%)	Infections (12%)	$2,500	1.0%
Top 10	**3,930,540**				**17.3%**

PHARMACY AND DRUG CLAIMS

The trends in pharmacy and drug claims both in total spending and on a PMPM basis are presented in Table 7. From 2004 to 2009, these expenses increased 50% from $3,348,376 to $5,038,797. This amount includes prescription drugs (brand and generics), drugs administered via home health and drugs administered in doctors' offices.

Table 7. Pharmacy and Drug Claims: Total and Per Member Per Month, 2004 to 2009

Pharmacy and Drug Claims: Total and PMPM, 2004 – 2009

Category	2004	2005	2006	2007	2008	2009
Total Spending	$3,348,376	$3,617,098	$3,904,845	$4,277,587	$5,124,785	$5,038,797
Total PMPM	$151.57	$155.86	$172.45	$209.73	$227.53	$231.23
Brand PMPM	$77.34	$77.57	$73.34	$81.94	$93.93	$108.50
Generic PMPM	$10.50	$19.46	$37.64	$52.40	$35.15	$26.62
Drugs (Home Health)	$24.86	$30.50	$21.97	$30.01	$58.28	$48.94
Drugs/Admin in MD Office	$38.87	$28.32	$39.50	$45.38	$40.17	$47.17

The sum of the 20 largest pharmacy claims grew by 5% in 2009, totaling $714,656 compared with $683,333 in 2008 (Table 8). This represents about 24% of all pharmacy claims in the recent 12 months. The largest pharmacy claim in the recent period was for $76,950.

Table 8. The 20 Largest Pharmacy Claims, 2009

Rank	2009	# of Drugs
1	$76,950	23
2	59,848	13
3	52,667	39
4	45,936	13
5	43,505	1
6	41,203	16
7	37,810	23
8	36,491	30
9	31,160	28
10	30,859	33
11	30,683	49
12	28,133	16
13	27,388	24
14	26,925	29
15	26,406	30
16	25,357	3
17	24,378	6
18	23,822	15
19	22,760	2
20	22,376	3

Table 9. Top Drugs by Dollars Spent, 2009

Rank	Name†	Cost	# Filled	Description
1	Copaxone	$144,845	63	Immune System (MS)
2	Gleevec	138,233	50	Cancer
3	Nexium	58,426	503	Stomach/Acid Reflux
4	Avonex	54,827	30	Multiple Sclerosis
5	Pulmozyme	52,533	24	Cystic Fibrosis
6	Truvada	50,336	49	HIV/AIDS
7	Cymbalta	46,349	424	Antidepressant
8	Humalog	38,723	360	Diabetes
9	Tarceva	38,375	14	Cancer
10	Lantus	38,285	485	Diabetes

TOP PROVIDERS

The three largest healthcare providers in 2009 were the University of Kansas Hospital Authority, Via Christi Regional Medical Center, and Shawnee Mission Medical Center. These three providers accounted for $4,615,755 of $24,068,791 or 19.2% of the total claims paid in 2009. Pharmacy claims were excluded from this comparison.

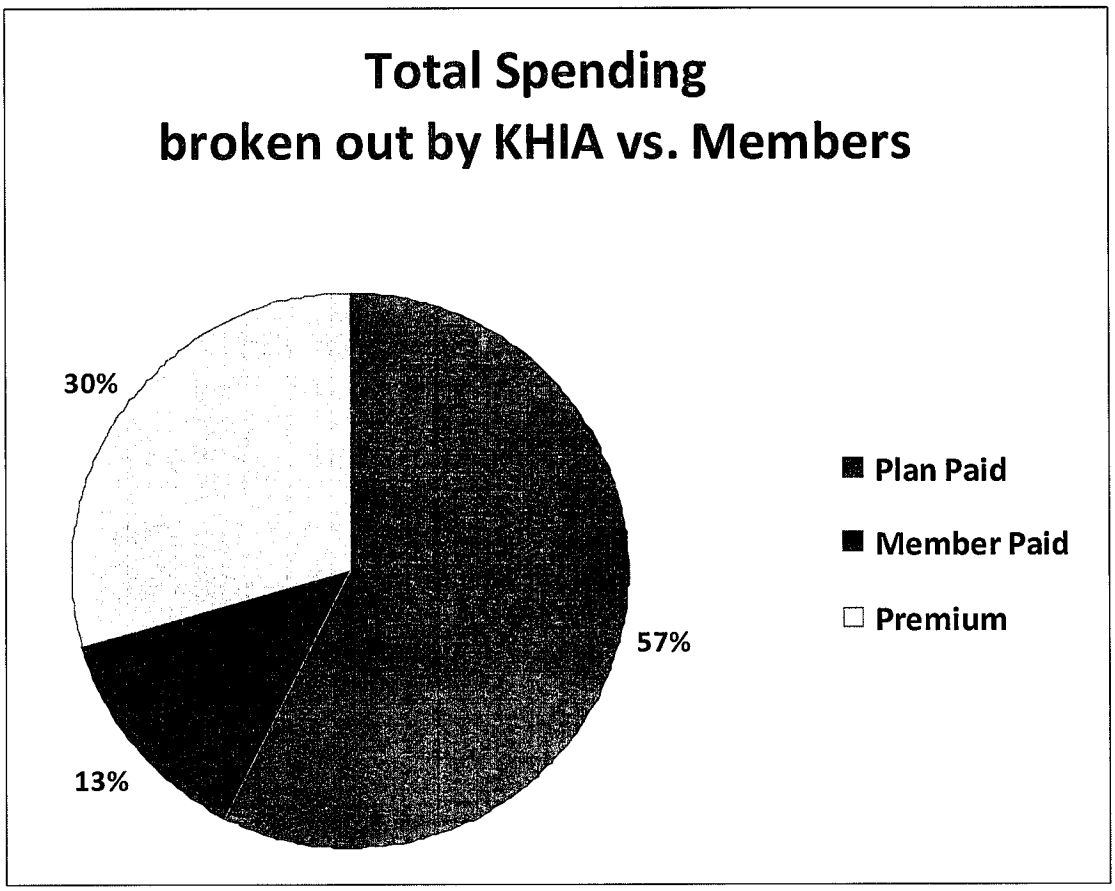
Table 10. Top Providers in 2009

SELECTED TOP PROVIDERS
UNIVERSITY OF KANSAS HOSPITAL
VIA CHRISTI REGIONAL MEDICAL CENTER
SHAWNEE MISSION MEDICAL CENTER
SALINA REGIONAL HEALTH CENTER
PROVIDENCE MEDICAL CENTER
HAYS MEDICAL CENTER
GAMBRO HEALTHCARE-OLATHE
STORMONT-VAIL HEALTHCARE
OLATHE MEDICAL CENTER INC
RENAL TREATMENT CENTERS-WEST
CAREMARK INC
CANCER CENTER OF KANSAS
MIDWEST DIVISION REGIONAL MEDICAL CENTER
UNIVERSITY HOSPITAL
FREEMAN-OAK HOSPITAL
ST FRANCIS HOSPITAL & MEDICAL CENTER
KANSAS HEART HOSPITAL
TRC PUYALLUP DIALYSIS
LAWRENCE MEMORIAL HOSPITAL
WESLEY MEDICAL CENTER
MIDWEST DIVISION - OPRMC
PRATT REGIONAL MEDICAL CENTER

TOTAL COMBINED COSTS IN 2009

Total combined spending for 2009 is the sum of claims paid by KHIA, premiums paid by enrollees, and unreimbursed expenses incurred by enrollees. The enrollee expenses include deductibles, copayments, and coinsurance. These combined amounts totaled $41,870,714 in 2009 (Chart 9). Premiums ($12,373,521) comprised 30% of the total. Enrollee paid expenses ($5,428,402) was 13%. KHIA's expense ($24,068,791) was 57% of the total. Note: KHIAs payout by the U.S. Department of Health and Human Services definition is 81.6%.

Chart 9. Spending by KHIA and Enrollees, 2009



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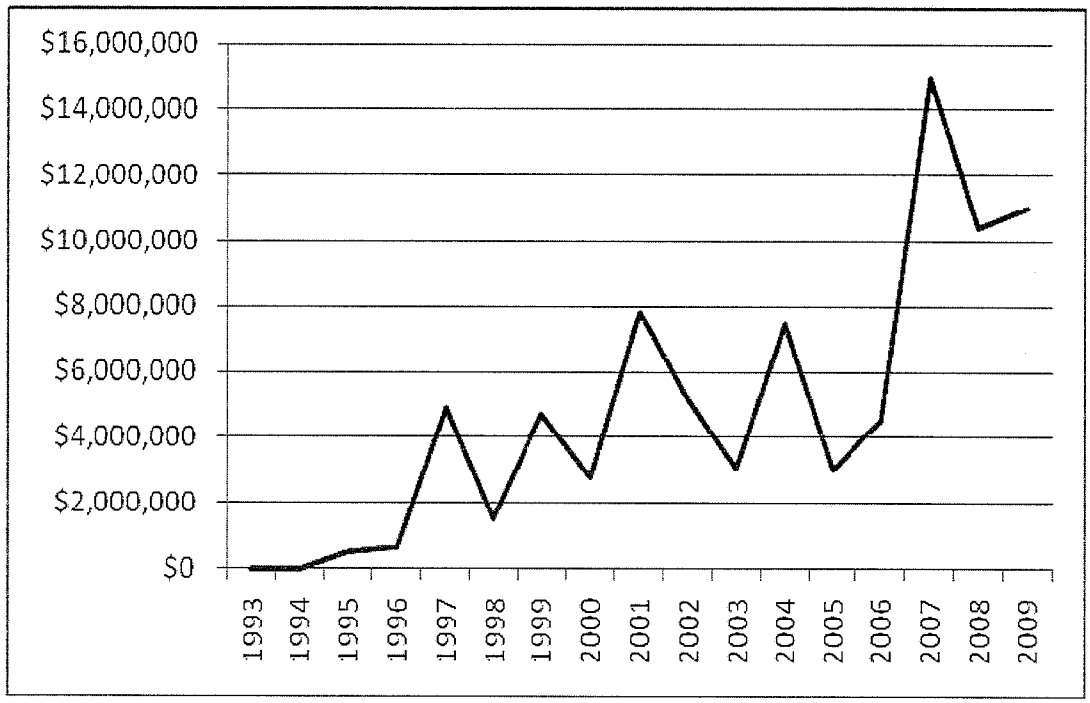
ASSESSMENTS

Since KHIA's inception, over $82 million has been assessed against the state's insurers to help cover the losses incurred by enrollees. During the last three years, assessments have totaled $15 million (2007), $10.385 million (2008) and $11 million in 2009 (Chart 10). The amount of the annual assessment has climbed steadily while enrollment has been relatively flat for the last 5 years. Large claims, medical inflation, and a sicker population have helped drive losses higher on a PMPM basis. The KHIA Board of Directors has keep premium increases as low as possible and maintained an average premium under 130% of the state's market basket.

Chart 10. Annual Member Assessments Since Plan Inception, 1993 to 2009



FEDERAL GRANT PROGRAM

KHIA and other state high risk pools have participated in a federal grant program since federal fiscal year 2003-2004. The state pools are provided flexibility in what incurred expenses are covered by the Operational Loss portion of the grant. Bonus grant funding began in 2006. States had an option to allocate these funds to improve affordability through a premium subsidy program or to improve wellness through a disease management program. KHIA chose the latter because of concerns about sustaining premium subsidies beyond any lapse in federal funding.

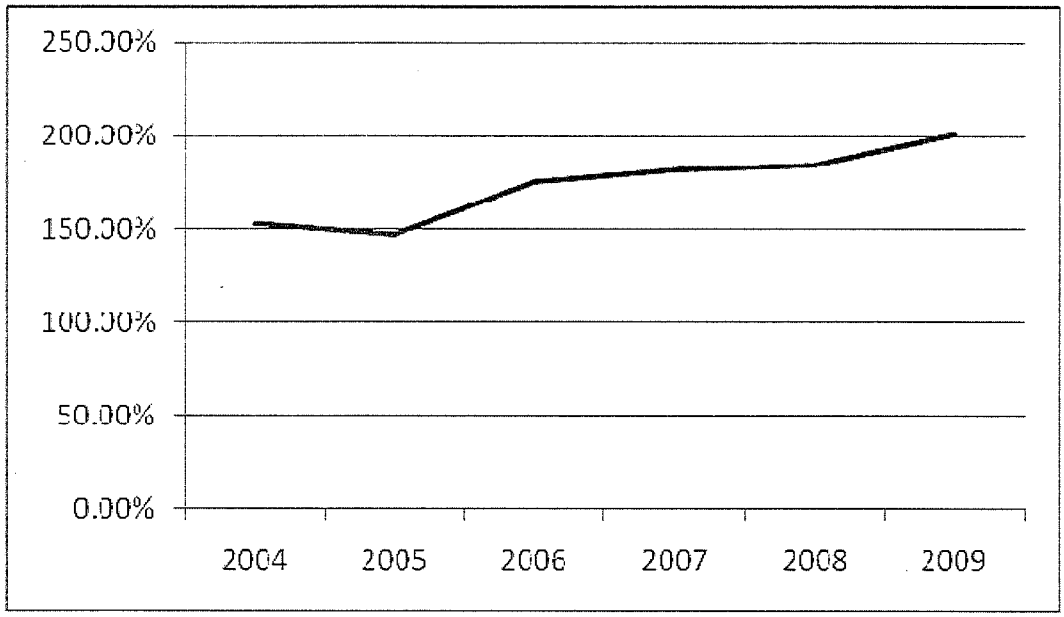
Table 11. Federal Grant Funds for KHIA Operational Losses and Disease Management, 2003 to 2009 (Note: year indicates federal fiscal year not the year in which the funds were expended or drawn.)

Year	Operational Losses	Bonus Funds
2003-04	$1,337,299	-
2004-05	$1,461,689	-
2005-06	$1,297,042	-
2006-07	$1,031,608	$295,000
2007-08	$1,085,624	$400,000
2008-09	$1,101,026	$566,202

MEDICAL LOSSES

The table below summarizes medical loss ratios by plan for 2008 and 2009. The total loss ratio for KHIA is 201.2% for both 2008 and 2009. The total loss ratio for KHIA from 2004 through 2009 is 175%.

Chart 11. Trend Line of Medical Loss Ratios for All Policies Combined, 2004 to 2009



Note that policies with lower deductibles have higher loss ratio than higher deductible plans.

Table 12. Medical Loss Ratios by Plan, 2008 and 2009

Deductible	2008	2009
$500	293.9%	228.9%
$1,000	138.6%	134.5%
$1,500	254.9%	270.2%
$2,500	179.3%	192.2%
$5,000	112.6%	163.0%
$7,500	148.2%	117.1%
$10,000	83.1%	93.8%

KHIA STAKEHOLDERS

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KANSAS INSURANCE DEPARTMENT

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Commissioner of Insurance

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Accident and Health Division

Julie Holmes, Assistant Director
Accident and Health Division

SERVICE PROVIDERS

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Benefit Management, Inc., Great Bend, KS

Actuary
Miller & Newberg, Inc., Overland Park, KS

Pharmacy Benefits Manager
Medco Health Solutions, Franklin Lakes, NJ

Utilization Review and Case Management
Optum Health, Golden Valley, MN

Bank and Trust
Emprise Bank, Wichita, KS

Auditor
Leemhuis Group, Indianapolis, IN

EXECUTIVE DIRECTOR

Edwin Fonner, Jr., DrPH, Lenexa, KS

KANSAS HEALTH INSURANCE ASSOCIATION

AUDITED FINANCIAL STATEMENTS, 2008 AND 2009

Report includes:

- Report of Independent Auditors
- Audited Financial Statements
- Balance Sheets
- Statements of Operations and Unassigned Surplus
- Statements of Cash Flows
- Notes to Financial Statements

LEEMHUIS GROUP

Report of Independent Auditors

Board of Directors
Kansas Health Insurance Association

We have audited the accompanying balance sheet of Kansas Health Insurance Association as of December 31, 2009, and the related statements of operations and unassigned surplus and cash flows for the year then ended. These financial statements are the responsibility of the Association's management. Our responsibility is to express an opinion on these financial statements based on our audit. The accompanying financial statements of the Association as of December 31, 2008 and for the year then ended were audited by other auditors whose report dated May 20, 2009 expressed an unqualified opinion on those statements.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Kansas Health Insurance Association's at December 31, 2009, and the results of its operations and its cash flows for the year then ended, in conformity with accounting principles generally accepted in the United States of America.

In accordance with *Government Auditing Standards*, we have also issued our report dated March 25, 2010 on our consideration of Kansas Health Insurance Association's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should not be considered in assessing the results of our audit.

Leemhuis Group

March 25, 2010

Balance Sheets

Kansas Health Insurance Association

	December 31 2009	2008
Assets		
Cash	$ 880,003	$ 10,347,262
Investments	15,980,342	6,094,523
Premium receivable	966,397	64,516
Assessment receivable	288,671	362,382
Grant receivable	1,577,228	-
Prepaid expenses	37,933	29,734
Total assets	$ 19,730,574	$ 16,898,417
Liabilities and unassigned surplus		
Reserve for unpaid claims	$ 5,217,464	$ 4,296,694
Unearned premium reserve	1,080,918	141,230
Abandoned claim reserve	181,860	-
General expenses due and accrued	22,101	56,711
Total liabilities	6,502,343	4,494,635
Unassigned surplus	13,228,231	12,403,782
Total liabilities and unassigned surplus	$ 19,730,574	$ 16,898,417

Statements of Operations and Unassigned Surplus

Kansas Health Insurance Association

	Year ended December 31	
	2009	2008
Operating revenues:		
Premiums earned	$ 11,916,751	$ 11,716,037
Operating expenses:		
Policy benefits incurred	23,363,694	24,234,287
Plan administration fees	442,332	352,087
Other general and administrative fees	751,988	747,247
	24,558,014	25,333,621
Operating loss	(12,641,263)	(13,617,584)
Non-operating revenues:		
Federal grant awards	2,662,852	987,758
Investment income	127,273	412,877
	2,790,125	1,400,635
Loss before assessments	(9,851,138)	(12,216,949)
Assessments	10,958,314	12,012,185
Surplus adjustment	(282,727)	-
Change in unassigned surplus	824,449	(204,764)
Unassigned surplus at beginning of year	12,403,782	12,608,546
Unassigned surplus at end of year	$ 13,228,231	$ 12,403,782

Statements of Cash Flows

Kansas Health Insurance Association

	Year ended December 31 2009	2008
Operating activities		
Premiums collected	$ 11,962,930	$ 11,757,085
Benefits paid	(22,671,416)	(22,264,200)
General administrative expenses paid	(1,020,921)	(1,136,567)
Cash used by operating activities	(11,729,407)	(11,643,682)
Investing activities		
Purchase of investments	(20,300,000)	(8,000,000)
Proceeds from sale or maturities of investments	10,132,825	8,757,244
Investment income	315,181	586,369
Cash provided from (used in) from investing activities	(9,851,994)	1,343,613
Financing activities		
Assessments collected	11,028,518	10,385,231
Federal grant receipts	1,085,624	987,758
Cash provided by financing activities	12,114,142	11,372,989
Net increase (decrease) in cash	(9,467,259)	1,072,920
Cash at beginning of year	10,347,262	9,274,342
Cash at end of year	$ 880,003	$ 10,347,262

Notes to Financial Statements

December 31, 2009 and 2008

1. Organization and Significant Accounting Policies

Organization

Kansas Health Insurance Pool (the "Association"), a nonprofit entity, was established by the Kansas Legislature in 1992 for the purpose of providing health care coverage for eligible persons in Kansas who have been rejected for individual coverage by licensed insurance carriers or who would not otherwise be able to obtain such coverage. The Association has the authority, under state law, to assess insurance companies writing health premiums in the State of Kansas for ail losses of the Association. Presently, assessments are made as funds are needed.

Basis of Presentation

The accompanying financia1 statements Rave been prepared in conformity with accounting principles generally accepted in the Unites States of America.

Use of Estimates

Preparation of financial statements requires management to make estimates and assumptions that affect amounts reported in the financial statements and accompanying notes. Such estimates and assumptions could change in the future as more information becomes known, which could impact the amounts reported and disclosed herein.

Cash and Investments

Cash represents deposits at the Association's banks, and due to the highly liquid nature of the balance, is stated at cost. All investments with a remaining maturity of three months or less at the date of acquisition are considered cash equivalents. Investments are recorded at market value.

Assessments

Assessments of the insurer members are approved by the Board of Directors and are recognized as a contribution to unassigned surplus. Assessments receivable represents outstanding balances assessed to insurance companies, but not yet collected.
Notes to Financial Statements

Unpaid Claims and Related Expenses

The liabilities for unpaid claims and related expenses are estimated based on historical claim development. Considerable variability is inherent in such estimates. However, management believes that liabilities for unpaid claims and related expenses are adequate. The estimates are continually reviewed and updated as experience develops or new information becomes known; such adjustments are reflected in current operations.

Premium deficiencies are not recognized as the Association has the statutory authority to assess member plans for operating losses.

Revenue Recognition

Premiums are earned pro rata over the periods to which the premiums relate. Premiums received in advance represent amounts received in advance of the policy effective date.

Income Taxes

The Association believes it is exempt from federal income taxes as provided for in Section 115 of the Internal Revenue Code. Accordingly, no provision for income taxes is provided for in the accompanying financial statements.

Concentration of Credit Risk

Interest bearing deposits at the Association's financial institutions are insured by the Federal Deposit Insurance Corporation up to $250,000 and non-interest bearing deposits are insured on an unlimited basis. At December 31, 2009 and 2008, none of the Association's cash balances are uninsured.

2. Investments

The following is a summary of investments as of December 31:

	2009		2008	
	Cost	Fair Value	Cost	Fair Value
Debt securities:				
Government bonds	$ 3,081,458	$ 3,057,903	$ 2,759,392	$ 2,796,837
Certificates of deposit	480,000	482,730	-	-
	3,561,458	3,540,633	2,759,392	2,796,837
Cash equivalents	12,439,709	12,439,709	3,297,686	3,297,686
Total investments	$ 16,001,167	$ 15,980,342	$ 6,057,078	$ 6,094,523

The cost and estimated fair value of debt securities at December 31, 2009, by contractual maturity, are shown below. Expected maturities may differ from contractual maturities because the issuers of the securities may have the right to prepay obligations without prepayment penalties.

	Cost	Fair Value
Due in one year or less	$ 3,296,967	$ 3,276,271
Due after one year through five years	264,491	264,362
	$ 3,561,458	$ 3,540,633

Accounting Standards Codification 820-10-35 establishes a fair value hierarchy for the inputs used to measure fair value based on the nature of the data input, which generally range from quoted market prices for identical instruments in a principal trading market (Level 1)to estimates determined using related market data (Level 3). The Association's debt securities have been valued using Level 1 inputs.

3. Federal Grant

During 2009 and 2008, the Department of Health and Human Services awarded the Association a High Risk Pool Grant to be used to fund operating losses of the Pool, and Bonus Grant funds to be used to implement a disease management program. The grant funds have been reported as non-operating revenue in the accompanying statements of operations and unassigned surplus.

	Year ended December 31	
	2009	2008
Operations Grant	$ 1,696,650	$ 933,790
Bonus Grant	966,202	53,968
	$ 2,662,852	$ 987,758

4. Liability for Unpaid Claims

The following table provides a reconciliation of the beginning and ending balances of the reserve for unpaid claims:

	Year ended December 31	
	2009	2008
Balances at January 1	$ 4,296,694	$ 3,964,911
Policy benefits incurred related to:		
Current year	23,853,099	23,846,209
Prior years (redundancy)	(489,405)	388,178
Total policy benefits incurred	23,363,694	24,234,287
Paid related to:		
Current year	18,779,719	19,667,664
Prior years	3,663,205	4,234,840
Total paid	22,442,924	23,902,504
Balances at December 31	$ 5,217,464	$ 4,296,694

Policy benefits incurred related to prior years varies from previously estimated liabilities as the claims are ultimately settled. The changes in amounts incurred related to prior years are the result of changes in morbidity experience, health care utilization and claim payment patterns.

5. Plan Administration Agreement

The Association has outsourced its administrative services to Benefit Management Inc., a Kansas based third party administrator, under a service agreement effective through December 201 1. In accordance with the agreement, the Association is charged a per-member-per-month fee based on the number of active members. Total fees paid to Benefit Management Inc. in 2009 and 2008 were $326,977 and $352,087, respectively.

6. Line of Credit

The Association has a secured revolving line of credit agreement with Emprise Bank, which provides for borrowing up to a maximum of $1,000,000. There were no outstanding balances at December 31, 2009 or 2008, nor were there any borrowings against this line during 2009 or 2008.

(End of Financial Statements)

Polsinelli Shughart PC

Memorandum

TO: Representative Brenda Landwehr, Chair
Joint Committee on Health Policy Oversight

FROM: William W. Sneed
Polsinelli Shughart PC

SUBJECT: Patient Protection and Affordable Care Act and its impact on the health insurance industry

DATE: November 4, 2010

Madame Chair, Members of the Committee: My name is Bill Sneed and I am with the law firm of Polsinelli Shughart PC. I have been asked to give a general overview on the Patient Protection and Affordable Care Act. As you are aware, I represent several clients with health policy interests. However, today I will not be representing any of those clients before this Committee, but sharing my professional knowledge of what PPACA does and its impact. I will be sharing that responsibility with Terry Brooks, who is also with Polsinelli Shughart. Terry is in our Washington DC office and has over 35 years of experience in health law

The Patient Protection and Affordable Care Act (the "Act") signed by President Obama on March 23, 2010 was intended to improve the performance, transparency and accountability of health insurers and health insurance products.

Today, I would like to take you through the changes that PPACA will require of insurers. And, I know a lot has been made that the full effect of this act will take place in 2014. However, many changes have already occurred and others will occur over the coming months.

Changes Effective Upon Enactment (March 23, 2010)

Protection against premium increases

- The Department of Insurance, in conjunction with the U.S. Department of Health and Human Services ("HHS"), will review "unreasonable" premium increases before the increases take effect.
- Health insurance companies are required to post information justifying premium increases on their Web sites.

Benefits for small businesses

- The Act provides tax credits for small businesses that contribute at least 50 percent of the premium cost for health coverage provided to employees.
- Businesses with 25 or fewer full-time employees and average annual wages of $50,000 or less will be eligible for tax credits of up to 35 percent of premium costs beginning with the 2010 taxable year.

555 South Kansas Avenue, Suite 101
Topeka, KS 66603

JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT
DATE: 11-4-10
ATTACHMENT: 6

- To clarify, businesses with 50 or fewer employees will not, at any time, be penalized for failing to offer health insurance to employees.

Changes to benefit seniors

- The Act begins to close the Medicare Part D "doughnut hole."
- Beginning in 2010, Medicare Part D recipients who hit the "doughnut hole" will be eligible for a $250 rebate.
- Beginning in 2011, recipients will be eligible for a 50 percent discount on brand-name prescription drugs in the "doughnut hole."

Changes within 90 days after enactment

Coverage for individuals with preexisting conditions

- Uninsured individuals with preexisting medical conditions will have increased access to coverage through a "high-risk" health insurance pool administered by the State and funded by the U.S. Department of Health and Human Services.
- To be eligible for new coverage under the high-risk pool, individuals must be uninsured for 6 months before applying and have a qualifying preexisting condition.

Reduced employer health care costs

- Employers will be allowed to reduce health care costs through a temporary "reinsurance" program for early retirees (age 55 years or older and ineligible for Medicare).
- Participating employers, including state and local governments, will be reimbursed for 80 percent of medical claims between $15,000 and $90,000 incurred by retired employees.

Changes effective 6 months after enactment – September 23, 2010

- Policies issued on or after September 23, 2010, will have to immediately comply with the reforms below.
- For policies issued between March 23, 2010, and September 22, 2010, the reforms below will apply as soon as the policies are amended or renewed after September 23, 2010.
- Policies that were issued prior to March 23, 2010, are considered "grandfathered" plans. Some of the reforms below will not apply to grandfathered plans.

Prohibition against unwarranted rescissions

- Health insurance rescissions will be prohibited except for instances of fraud.

Coverage for preventive services

- All health insurance plans will be required to provide first-dollar coverage for a defined set of preventive benefits. In other words, insurers will be required to include wellness and prevention benefits such as immunizations and screenings, without cost to the policyholder.

6-2

Elimination of lifetime dollar limits

- Health insurance plans will be prohibited from imposing lifetime dollar limits.
- A health insurance company's ability to impose annual dollar limits will also be restricted (annual dollar limits will be prohibited entirely beginning in 2014).

Appeal process

- For the internal claims appeal process, group plans must incorporate the Department of Labor's claims and appeals procedures and update them to reflect standards established by the Secretary of Labor. Individual plans must incorporate applicable law requirements and update them to reflect standards established by the Secretary of HHS.
- The Act will require all plans, including self-insured plans, to provide an independent, external review of denied health insurance claims.

Improved coverage for children

- Current Kansas law allows health insurance companies to deny an application for insurance coverage based on past or present medical conditions. In addition, health insurance companies may permanently exclude coverage for a specific condition, or deny claims for otherwise covered medical treatments on the grounds that a condition was preexisting.
- Health insurance companies will, at a minimum, be prohibited from denying claims for covered children under the age of 19 due to the presence of a preexisting condition. The U.S. Department of Health and Human Services will be providing guidance as to whether the Act requires health insurance companies to accept all applications for coverage of children under the age of 19.
- Young adult children, up to age 26, will be able to receive coverage through a parent's health insurance policy. Self-insured plans, which are exempt from this law, will now be required to allow coverage for adult children under age 26 if the plan provides coverage for dependents.

Easier access to health care providers

- If a plan provides coverage for emergency services, the plan must do so without prior authorization regardless of whether the provider is a participating provider.
- Women may receive treatment from a network obstetrician or gynecologist without first having to obtain a preauthorization or referral from her primary care provider.

Additional information for consumers

- Health insurance companies will be required to publish detailed information about the percentage of each premium dollar the company spends on health care (called a "medical loss ratio").
- Health insurance companies will be required to publish additional information regarding the company's claims payment policies and practices, including the number of claims the company denies, as well as information regarding cost-sharing and payments for out-of- network coverage.

6-3

Changes Effective January 1, 2011

Premium value and transparency

- Health insurance companies that spend less than a certain percentage of premium dollars on health care will be required to rebate excess premiums to policyholders.
- For plans sold to individuals and small employers, health insurance companies will be required to spend 80% of premium dollars on health care. For plans sold to employers with more than 50 employees, health insurance companies will be required to spend 85%.

National Association of Insurance Commissioners

One element of the new federal law that has not been discussed much is that the jobs of enforcing the insurance regulations, of operating the health insurance exchanges and generally of regulating insurance are left to the states. Indeed, the health overhaul leaves state insurance law in place, only preempting laws that prevent its application.

To help coordinate state regulatory efforts, health reform looks to the National Association of Insurance Commissioners. In 10 provisions, the new health law explicitly assigns reform responsibilities to or requests help from the NAIC. One section requests the NAIC to amend its Medigap plan standards; another asks the NAIC to establish definitions and methodologies to be "certified" by the Department of Health and Human Services (HHS) for determining whether insurers pay out enough of their premiums for claims or quality improvement costs (the "medical loss ratio" requirement). A number of other provisions require HHS to consult with the NAIC or to take it advice into account in drafting implementing regulations. (Chart attached with specific responsibilities).

The NAIC has been implementing health reform since its was signed into law in March. Working groups and committees have held hours of conference calls and have already drafted medical loss ratio instructions and instructions for justifying unreasonable premium increases.

I am available for questions at your convenience.

Respectfully submitted,

William W. Sneed

WWS:kjb
Attachments: 1

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HEALTH CARE REFORM
NAIC/COMMISSIONER RESPONSIBILITIES
April 2010

Issue	Responsibility	Timeline	Citation
Medical Loss Ratio Accident and Health Working Group of the Life and Health Actuarial Task Force Health Reform Solvency Impact (E) Subgroup	NAIC to develop report establishing uniform definitions and standardized methodologies for calculating the MLR.	Report by December 31, 2010. Rebate program begins January 1, 2011.	Section 2718 of PHSA Sec 10101 of PPACA
Rate Review Speed to Market (EX) Task Force Accident and Health Working Group of the Life and Health Actuarial Task Force Health Reform Solvency Impact (E) Subgroup	Grants provided to states that meet minimum federal rate review procedures. Commissioner must report on authority.	Immediate implementation of Sec review of "unreasonable" rates and establishment of grant program	Sec 2794 of PHSA Sec 1003 of PPACA
Standard Definitions, Disclosures and Uniform Summary of Benefits Health Insurance and Managed Care (B) Committee	NAIC to develop standards and in conjunction with consumer and industry reps and submit to the Sec.	To be submitted by the NAIC by March 2011; to be used by plan beginning March 2012	Sec 2715 of PHSA Sec 1001 of PPACA
Uniform Enrollment Consumer Information (B) Subgroup	NAIC to submit criteria for uniform enrollment form to be used in Exchanges.	Implementation January 1, 2014	Sec 1311 of PPACA
Individual and Group Market Reforms Regulatory Framework (B) Task Force	NAIC to consult on definition of age bands and rating areas. NAIC to provide assistance to Sec and models for states.	Implementation January 1, 2014	Sec 2701 of the PHSA Sec 1201 of PPACA
Exchanges Exchanges (B) Subgroup	NAIC to consult on regulations establishing Exchanges.	Implementation January 1, 2014. Notification to HHS by January 1, 2013.	Sec 1321 of PPACA
Data Collection by Secretary and the State Health Insurance and Managed Care	Data to be submitted to the Secretary and Insurance Commissioners by all insurers (including self-	Implementation September 23, 2010	Sec 2715A of PHSA Sec 10101 of PPACA

6-5

HEALTH CARE REFORM
NAIC/COMMISSIONER RESPONSIBILITIES
April 2010

(B) Committee Market Regulation and Consumer Affairs (D) Committee	insure). Info can be collected by the NAIC.		
Medigap Reforms Senior Issues (B) Task Force	NAIC to amend Medigap model to add cost-sharing to Plans C and F	Adopted December 23, 2010 – Implementation 2015	Sec 3201 of PPACA
Interim Reinsurance Program and Risk Adjustment Mechanism Accident and Health Working Group of the Life and Health Actuarial Task Force	NAIC to consult on establishment of risk adjustment and interim reinsurance program. Reinsurance assessments to be based on NAIC estimates.	Implementation January 1, 2014	Sec 1341 of PPACA
Uniform Fraud Reporting Form ERISA (B) Subgroup Antifraud (D) Task Force	NAIC to develop model standards and forms for private insurers to report fraud and abuse to insurance commissioners and other state officials.	Immediate implementation.	Sec 2794 of PHSA Sec 6603 of PPACA
Interstate Compact Standards Health Care Reform Interstate Compact Standards (EX) Subgroup	NAIC to develop standards for voluntary interstate compacts that will permit sales across state lines.	Regs due July 1, 2013; States may enter into compacts January 1, 2016.	Sec 1333 of PPACA
External Review	Insurers must comply with the patient protections included in the NAIC's Uniform External Review model.	Implementation September 23, 2010	Sec 2719 of PHSA Sec 1001 of PPACA
Cost Containment Health Care Reform Cost Containment (EX) Subgroup	Track state efforts and federal pilot programs (not in legislation).	N/A	N/A

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MARK THE DATES

Health Reform Dates
You Need to Know and Care About if You Employ More than 50 Employees

2010 – Coverage Mandates

No later than the first plan year on or after September 23, 2010, the employer's health plan must be amended as follows:

- No lifetime limits on coverage for "essential health benefits"
- No pre-existing condition limitations for children under age 19
- An adult child of an eligible employee can maintain coverage under employer's plan until age 26 (unless other coverage available; no coverage required for child's spouse/children)
- If the plan is new or makes material changes in design or coverage on or after March 23, 2010, the plan must also:
  - Offer "first-dollar coverage" for preventive care services
  - Be provided in a non-discriminatory manner to all eligible employees
  - Enhanced claim appeal processes required

2011 – Miscellaneous Modifications

- Over-the-counter medications can no longer be considered a "qualifying medical expense" under cafeteria plans, health savings accounts ("HSA") and health reimbursement arrangements ("HRA")
- Non-medical distributions from an HSA are subject to a 20 percent excise tax
- Wellness programs can be enhanced (up to 30 percent premium discounts are allowable)

2012 – Maximum Contributions to Health FSA's

- The maximum contributions to a Section 125 flexible spending account will be $2,500

over →

Polsinelli Shughart PC

MARK THE DATES

2013 – Increased Medicare Taxes

- Medicare tax on employee wages increases to 2.45 percent for higher income employees
- New Medicare tax of 3.8 percent on "unearned income" for similar high income individuals

2014 – Enhanced Health Insurance Alternatives

- Employers who maintain current health plans must:
  - Not utilize annual or lifetime limits on plan coverage for "essential health benefits"
  - Eliminate pre-existing condition limitations for all newly eligible participants
  - If offer family coverage, provide coverage option to child to age 26 regardless of other coverage options
- Employer can be subject to per-employee penalties if no employee coverage offered, or coverage offered is below minimum thresholds or is more expensive based on the individual's household income
- All individuals, including employees and small employers, shall be entitled to purchase health insurance coverage through newly established Health Care Exchanges

Steps to Take Now

- Implement immediate health care mandates for 2010
- Watch for coverage changes and new limitations in 2011 and 2012
- Plan for increased contributions and changes in health care design and cost beginning in 2013 and beyond and consider alternative strategies as a result

For more information, please contact:

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polsinelli.com

KANSAS MEDICAL SOCIETY
Established 1859

To: KHPA Oversight Committee

From: Jerry Slaughter
Executive Director

Date: November 3, 2010

Subject: Impact of federal health reform on physicians

We were asked to briefly summarize the impact of the recently-enacted health reform legislation on physician practices. As you know, the health reforms passed earlier this year consisted of two principal elements: the "Patient Protection and Affordable Care Act" (H.R. 3590), and the "Health Care Education Affordability Reconciliation Act" (H.R. 4872). Both of these companion bills are now collectively referred to as the "Affordable Care Act" or the "ACA."

It is worth noting that even though this legislation has been signed into law, the health reform debate and process is far from over. In many respects, it has just begun. We don't yet know how the litigation over the individual mandate to purchase insurance will turn out. And, after the elections this week, it is expected that the new congress will attempt to repeal, or failing that, modify certain aspects of the legislation. While outright repeal is probably not possible, it is almost certain that congress will begin a process of amending the legislation that will most likely never end. One thing is almost certain: the improbable projections that health spending will be significantly slowed by the legislation will no doubt prove to be an illusion. That reality alone will require congress in coming years to consider greater controls on services, prices, and inputs to the system.

While much of the attention up to now has been focused on the higher profile parts of the ACA, including the individual mandate and the various insurance reforms, attention will now begin to turn to the less well known provisions that for most health care providers really represents the essence of the reform package. I would like to emphasize that the following list is by no means exhaustive of the provisions in the reform legislation, but just a sampling of those elements that will affect physicians.

Before summarizing those provisions, it should be mentioned that the sheer number of new entities created by the ACA, their immense reach, and the broad powers delegated to the Secretary of HHS to establish a regulatory framework around them, makes any definitive assessment of the full impact of this legislation nearly

impossible at this juncture. Many of the details concerning implementation of the ACA will not be known until federal agencies and state agencies issue guidelines on the new law and implementation begins in earnest.

Additionally, the number of newly-insured individuals as a result of the combination of Medicaid expansions and growth in the number of privately insured individuals could approach 200,000 Kansans by 2014. It is likely to be very challenging for the existing health workforce to absorb that kind of growth without some difficulty along the way.

Having said all that, the following are some of the more obvious programs that will have an impact on physician practices:

Quality Provisions
HHS Secretary to establish and update annually a national strategy for quality improvement to improve the delivery of health care services, patient health outcomes, and population health

Comparative Effectiveness Research: creates Patient-Centered Outcomes Research Institute to identify research priorities and establish and research project agenda

Continues voluntary Medicare quality reporting payment incentives (Physician Quality Reporting Initiative (PQRI); and beginning 2015 implements penalties for not reporting

HHS initiatives on care coordination, chronic disease management, medication and care compliance initiatives; non-payment for preventable hospital readmissions and healthcare acquired conditions, appropriate use of best clinical practices, evidence-based medicine, and health information technology

Medicare Physician Payment
A major disappointment for physicians was that the ACA did not address the deeply flawed formula called the Sustainable Growth Rate (SGR), which determines how Medicare will pay for physician services. It remains unsettled, and congress must repeatedly act to avert planned cuts that the SGR calculation produces on an annual basis. Other provisions that addressed physician Medicare and Medicaid payments:

- **Primary Care Bonus** – physicians in family medicine, internal medicine, geriatrics and pediatrics whose Medicare charges for certain primary care services will be eligible for a temporary 10% bonus payment for those services from 2011-2015

- **Medicaid Primary Care Payment Parity with Medicare** - temporarily requires that Medicaid payment rates to primary care physicians for certain primary care services be no less than 100 percent of Medicare payment rates in 2013 and 2014
- **Innovative Practice Models and the Patient Centered Medical Home –** promotion of practice models that could enhance payment for primary care through a Center for Medicare and Medicaid Innovation within CMS; also promotes the patient-centered medical home
- **Rural General Surgery Bonus** – general surgeons who perform major surgical procedures in designated rural areas will be eligible for a temporary 10% bonus payment for those services from 2011-2015
- **Geographic Payment Differentials** – extends the "floor" on Medicare's geographic payment adjustment for physician practice expenses component in rural areas

Graduate Medical Education
Provides grants and Graduate Medical Education funding for Teaching Health Centers to train primary care physicians in community based settings, beginning in 2010.

National Health Care Workforce Commission
Establishes a National Health Care Workforce Commission, to provide recommendations to Congress and Administration on national health workforce priorities, goals, and policies. Included is a mandate to make recommendations for eliminating the barriers to entering and staying in primary care, including provider compensation.

Administrative Simplification
National rules will be developed and implemented between 2013 and 2016 to standardize and streamline health insurance claims processing requirements, making it easier to track claims and hopefully improve provider revenue cycles

Alternative Delivery Models
Participants in Accountable Care Organizations (ACO) share cost savings resulting from coordinated care for assigned Medicare beneficiaries. Also authorizes pilot programs to encourage hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models

Independent Payment Advisory Board (IPAB)
Establishes IPAB which must submit recommendations to Congress, beginning in 2014, to reduce the growth of Medicare expenditures while maintaining or improving the quality of care delivered. The Secretary of HHS would be required to implement these recommendations unless Congress passed an alternative proposal that provided an equivalent amount of budgetary savings. If the bill's anticipated savings do not materialize, there could be immense pressure to use the IPAB as a tool to enforce difficult spending and benefits decisions outside of the legislative process.

Health Exchanges
Because they will be the portal through which virtually all private insurance is accessed, the control and operation of the state-based health exchanges mandated by the law presents a great deal of uncertainty about how providers will participate and be compensated under those arrangements.

Health Reform - *What Does it Mean for Hospitals?*

Health Policy Oversight Committee

November 4, 2010

Presented by Tom Bell

9 General Categories

- Health insurance
- Medicare/CHIP expansion
- Delivery system and reforms
- Medicare/Medicaid payment changes
- Quality
- Workforce/ Graduate Medical Education
- Reporting information
- Prevention and wellness
- Program integrity and oversight

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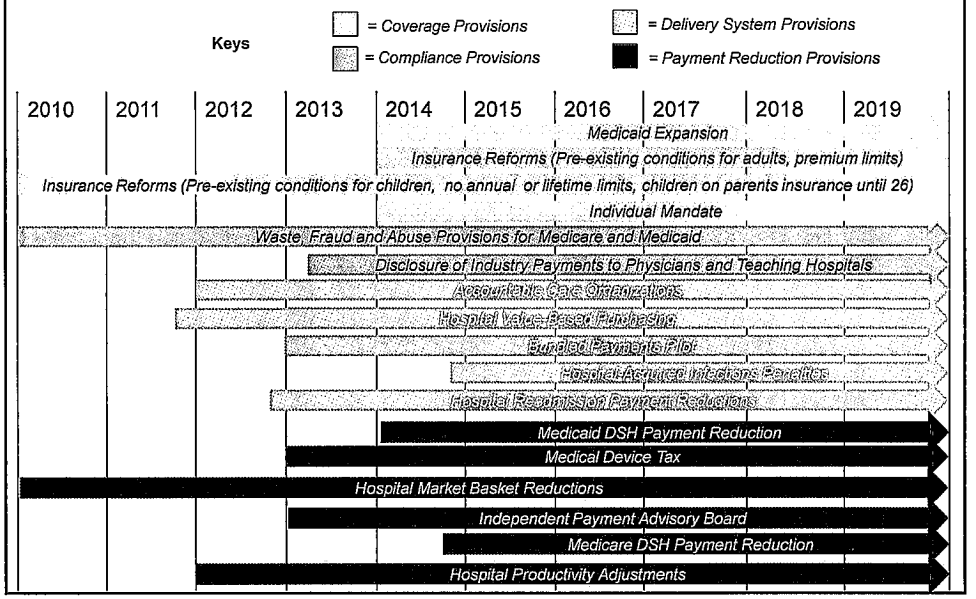
Health Reform Implementation Timeline



Direction for Payment and Delivery System Reform

Current Fee-For Service Payment Systems	Previously Recommended Tools	New System Changes
• Ambulatory surgical centers • Clinical laboratory • Durable medical equipment • Home health care • Hospice • Hospital acute inpatient • Inpatient rehabilitation facility • Long-term care hospital • Outpatient dialysis • Outpatient hospital • Physician • Psychiatric hospital • Skilled nursing facility	• Using comparative-effectiveness information • Linking payment to quality • Reporting resource use • Bundling individual services within a payment system (e.g., dialysis) • Creating pressure for efficiency through updates	• Medical home • Payments "bundled" across existing payment systems (e.g., hospital and physician around hospitalization) • Accountable care organization (e.g., physician group practice demo)

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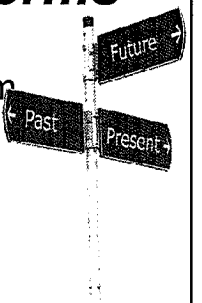
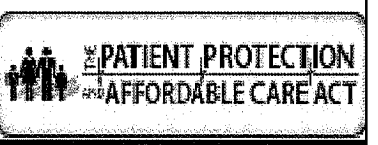
Key Implementation Areas

Delivery System Reforms



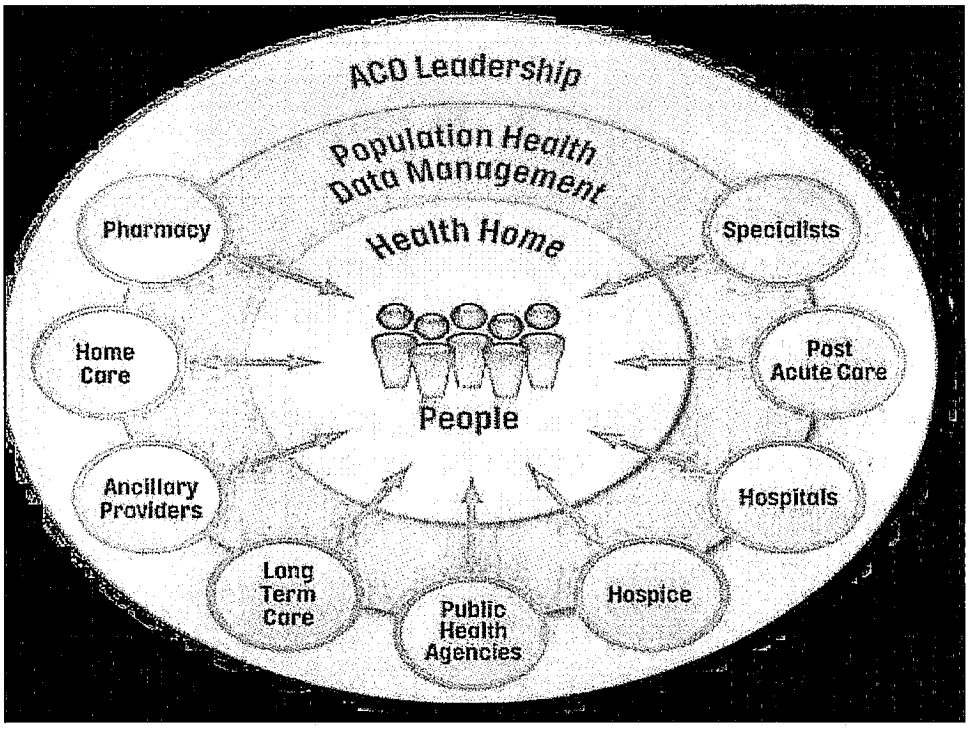
- Integrated care models of delivery system reform (ACOs, bundling, medical home, CMS Center for Innovation)
- Major hospital payment changes (update reductions, VBP, readmissions, hospital-acquired conditions (HACs), variation)
- National Quality Strategy
- Reducing health disparities



Health Reform Implications for Hospitals

Accountable Care Organizations

- Voluntary national pilot program beginning in 2012
- Groups of providers and hospital can take the lead
- All in the ACO would share in the Medicare cost savings they achieve
- Secretary would reset spending benchmarks every three years



Health Reform
Payment Bundling

- Five year national pilot program beginning in 2013
- Participation voluntary
- All Acute and non-acute services from 3 days prior to admission to 30 days post discharge for 8 conditions
- Composed of hospitals, physician groups, SNFs, and HHAs

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Health Reform

Value Based Purchasing

- Beginning in FY 2013 would establish a "budget neutral" program for all PPS hospitals
- Establishes a demonstration program for CAHs
- Up to 2 percent of Medicare IP payments would be reallocated based on quality performance
- Efficiency measures to be added
- Prohibits use of readmissions measures

Health Reform

Hospital-Acquired Conditions

- Hospitals in the top 25th percentile of rates of hospital-acquired conditions receive a 1% reduction in payment the hospital would have otherwise received, starting in 2015.

- The law also provides that a report on hospital-acquired conditions will be provided to hospitals and will be made available to the public.

Health Reform
Coverage Expansion

Over 10 years will expand coverage to 34 million – 95% of all Americans

- State-based health insurance Exchanges
- Non-profit health insurance co-ops
- Medicaid expansion
  - 133% FPL beginning 2014
- Subsidies for families up to 400% FPL
- Employer and individual mandates

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Health Reform
Coverage Expansion

What it means in Kansas

- Current estimates of 335,000 uninsured
- 190,000 (57%) will gain coverage
  - Of which 131,000 will be Medicaid
- 143,000 (5% of population) will opt out or be non-US citizens

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Regulatory Environment

- Coding Adjustment
- Low-Cost County Adjustment
- Low-Volume Hospital Adjustment
- Modifications to the 3-Day Payment Window
- Extension of MDH for 1
- Paying CAHs 101% under Method 2
- Transfer policy
- Payment of CRNA services
- Provider taxes as allowable costs
- Physician Supervision
- Quality Reporting
- Changes to Partial Hospitalization

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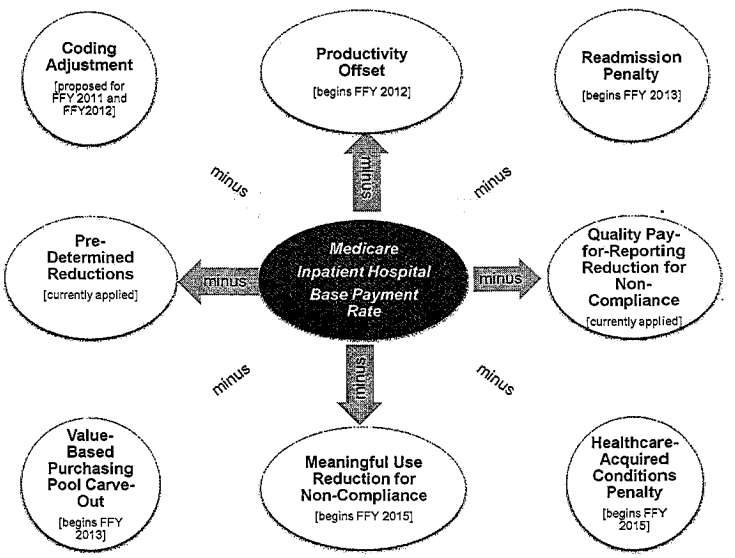
Medicare Hospital Base Payment Rate



Strategic Issues for Hospital Leaders

Success in the post-reform era will require work on many strategies simultaneously –

- Enhance efforts to improve quality and patient safety to reduce variation in care
- Increase clinical and operational efficiencies
- Increase efforts to improve patient satisfaction
- Develop new organization competencies for clinica integration and foster better alignment with physicians

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Strategic Issues for Hospital Leaders

- Develop strategies to reduce avoidable readmissions
- Identify community partners and conduct community needs assessment
- Assess and strengthen your plan for health information technology and EHR
- Examine readiness for episodic payment, care redesign across the continuum

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A Sea of Change in Health Care

- **Coordination and Collaboration** – Overcome fragmentation so that care across the continuum is convenient and coordinated for people
- **Data Collection and Use** – Need consistent data across care settings to measure progress when no such information exists today
- **Measure Value** – Better savings, quality improvements and increased satisfaction
- **Population Health Focus** – Reward wellness rather than services provided
- **Time** – Long-term commitment, so efforts toward transformation need to start now
- **Shared Savings** – Aligning reimbursement so providers can capture income based on savings delivered

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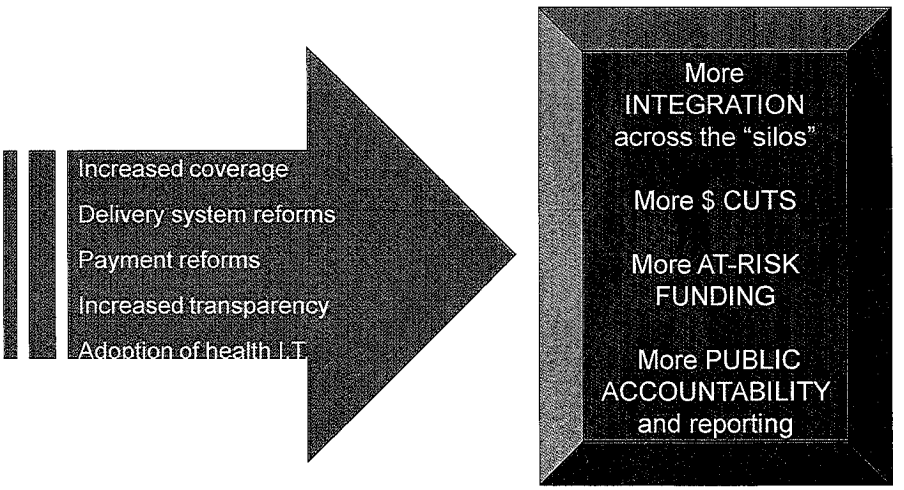

Polsinelli Shughart PC

Memorandum

TO: Joint Committee on Health Policy Oversight

FROM: Teresa A. Brooks
Polsinelli Shughart PC

SUBJECT: Patient Protection and Affordable Care Act

DATE: November 4, 2010

Madame Chair, Members of the Committee: My name is Terry Brooks with Polsinelli Shughart and I am a shareholder from our Washington, D.C. office. It is a pleasure to be with you today. For more than 35 years I have been involved in the healthcare industry representing a broad range of clients, including providers, units of government, associations and health-related companies. However, today I will not be representing any of those clients before this Committee.

This afternoon, I would like to discuss some of the changes that the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (together referred to the Act or the Affordable Care Act) has and will make to the existing health system and the challenges that we face going forward. While the many of the significant provisions do not take effect until 2014, implementation activities are underway and a number of changes, including those affecting providers, are being implemented. The law is intended to expand coverage, improve quality and efficiency and being managing the cost of healthcare. This Chart highlights some of the most significant provisions.

Year	Provision
2010	
	Medicare Provider Payment Rates: Reduces annual market basket (MB) updates for inpatient hospital services (IPPS) and outpatient hospital services (OPPS), long term care hospitals (LTCH), inpatient rehabilitation facilities (IRF) and psychiatric hospitals (IPF) and units and adjust payments. Productivity adjustments begin in 2012. January 1, 2010 • MB-.25% for OPPS (January 1, 2010) April 1, 2010 • MB-0.25% for IPPS hospitals, IRFs and LTCHs (April 1, 2010) July 1, 2010 • MB-25% for IPF (July 1, 2010)

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October 1, 2010

- MB-0.25% for IPPS and IRF (FY 2011)
- MB-0.5% for LTCH (FY 2011)
- MB-3% for hospice (FY 2011)

Rural Laboratories: Reinstates reasonable cost reimbursement for laboratory services in small rural hospitals through June 30, 2011. Implementation: July 1, 2010.

Wage Index Floor for Frontier States: Application of wage index floor of 1.0 for frontier states annually thereafter (October 1, 2010).

Rural HHAs: Reinstates 3% add-on payment for rural home health provider through 2015.

Physician Ownership of Hospitals: Eliminates the physician-owned hospital exception under Stark law if no provider agreement prior to December 31, 2010; Grandfathers providers with existing agreements.

Medicaid and CHIP Payment Advisory Commission: Provides funding for and expands the role of the Medicaid and CHIP Payments and Access Commission to include assessments of adult services. Funds appropriated for FY 2010.

Patient-Centered Outcomes Research Institute (PCORI): Establishes the patient-centered outcomes research institute to set a national research agenda and conduct comparative clinical effectiveness research that compares the clinical effectiveness of medical treatments. Funding appropriated beginning FY 2010.

Prevention and Public Health Fund: Appropriates $5 billion for FYs 2010 through 2014 and $2 billion for each subsequent FY to support prevention and public health programs. Funding appropriated beginning FY 2010.

Medicare Beneficiary Drug Rebate: Provides $250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010. Further subsidies and discounts that ultimately close the coverage gap begin in 2011. Implementation: January 1, 2010.

Medicaid Drug Rebate: Increases the Medicaid drug rebate percentage for brand name drugs to 23.1% (except for rebate for clotting factors and drugs approved exclusively for pediatric use) increases to 17.1% and to 13% of average manufacturer price for non-innovator, multiple source drugs. Extends the drug rebate to Medicaid managed care plans. Implementation: January 1, 2010 for increase in Medicaid drug rebate percentage; March 23, 2010, for extension of drug rebate to Medicaid managed care plans.

Coordinating Care for Dual Eligibles: Establishes the Federal Coordinated Health Care Office to improve care coordination for dual eligibles (people eligible for both Medicare and Medicaid). Implementation: March 1, 2010.

New Requirements on Nonprofit Hospitals: Imposes additional requirements on non-profit hospitals to conduct community needs assessments and develop a financial assistance policy and impose a tax of $50,000 per year for failure to meet these requirements. Implementation:

March 23, 2010.

Medicaid Coverage for Childless Adults: Creates a state option to provide Medicaid coverage to childless adults with incomes up to 133% of the federal poverty level (FPL) and receive current law FMAP. States will be required to provide this coverage in 2014. Implementation: April 1, 2010.

New Prevention Council: Creates the Prevention, Health Promotion and Public Health Council to develop a national prevention, health promotion and public health strategy. Implementation: First report due July 1, 2010.

Expansion of Drug Discounts Program: Expands eligibility for the 340(B) drug discount program to sole community hospitals, critical access hospitals, certain children's hospitals and other entities. Implementation: applications accepted beginning August 2, 2010.

Coverage of Preventive Benefits: Requires new health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the US Preventive Services Task Force (USPSTF), recommended immunizations, preventive care for infants, children and adolescents, and additional preventive care and screenings for women. Implementation: Plan or policy years beginning on or after September 23, 2010.

Medically Underserved Areas: Directs a negotiated rulemaking, with stakeholders, to establish a methodology and criteria for designating medically underserved populations and HPSAs. Implementation: March 23, 2010.

Health Centers and National Health Service Corps (NHSC): Permanently authorizes the federally qualified health centers (FQHCs) and the NHSC programs and increases funding for FQHCs and for the NHSC for FYs 2010-2015. Implementation: Funding appropriated beginning fiscal year 2010.

Health Care Workforce Commission: Establishes the National Health Care Workforce Commission to coordinate federal workforce activities and makes recommendations on workforce goals and policies and establishes the National Center for Health Workforce Analysis to undertake state and regional workforce data collection and analysis. Implementation: Initial appointments to the National Health Care Workforce made by September 30, 2010.

- Increases workforce supply and supports training of health professional through scholarships and loans.

Medicaid Community Based Services: Provides states with new options for offering home and community based services through a Medicaid state plan amendment to certain individuals and permits states to extend full Medicaid benefits to individuals receiving home and community-based services under a state plan.

Medicaid Recovery Audit Contractors: State must contract with one or more Recovery Audit Contractors (RAC) to identify underpayments and overpayments. Implementation: By December 31, 2010.

2011	
	Medicare Provider Payment Rates. January 1, 2011 • MB-0.25% for OPPS (January 1, 2011) • MB-1.0% for HHAs (January 1, 2011) • MB-1.75%+productivity for clinical labs (January 1, 2011) • Provider specific HHA outlier cap of 10%; annually thereafter (January 1, 2011) • MB-productivity for ASCs, certain DME, ambulance (January 1, 2011) July 1, 2011 • MB-0.25% for IPF (July 1, 2011) October 1, 2011 • MB-(0.1%+productivity) for IPPS, LTCH and IFR • MB-productivity for SNF • MB-(0.3%+productivity) for hospice • Delays for 1 year the implementation of certain "RUGs-IV Medicare payment changes. Medicare Advantage Payment Changes: Restructures payments to private Medicare Advantage plans by phasing in payments set at increasingly smaller percentages of Medicare fee for services rates; freezes 2011 payments at 2010 levels; and prohibits Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional FFS program. Implementation: January 1, 2011. Medicare Wage Index: Medicare wage index reform plan is due December 31, 2011. Protections for Frontier States: Establishes minimum floor of 1.0 for the Medicare IPPS and, OPPS for hospitals and for the Physician Fee Schedule in Frontier states where at least 50% of the counties have fewer than 6 people/square mile (NV, ND, SD, MT, WY, UT). Implementation: FY 2011 and beyond. Payments to Qualifying Hospitals in Medicare "Low Cost" Counties: For FY2011 and FY 2012, $200 million in each year will be paid to hospitals in counties that rank in the lowest quartile of Medicare per beneficiary spending. Implementation: FY 2011 and FY 2012. Payment Reductions for Imaging Services: Reduces payments for imaging services based on equipment utilization factors. Implementation: January 1, 2011. Medicare Payments for Primary Care: Provides a 10% Medicare bonus payment or primary care services; also provides a 10% Medicare bonus payment to general surgeons practicing in health professional shortage areas. Implementation: January 1, 2011 through December 31, 2015. Nurse Midwife Services: Increases reimbursement for certified nurse-midwife services from

	65% to 100% of PFS rate Implementation: January 1, 2011. Physician Assistants and SNF services. Permit physician assistants to order SNF services. Implementation: January 1, 2011. Closing the Medicare Drug Coverage Gap: Requires pharmaceutical manufacturers to provide a 50% discount on brand name prescriptions filled in the Medicare Part D coverage gap beginning in 2011 and begins phasing in federal subsidies for generic prescriptions filled in the Medicare Part D coverage gap. Implementation: January 1, 2011. Medicare Prevention Benefits: Eliminates cost-sharing for Medicare-covered preventive services that are recommended (rated A or B) by the US Preventive Services Task Force (USPSTF) and waives the Medicare deductible for colorectal cancer screening tests; authorizes Medicare coverage for a personalized prevention plans, including a comprehensive health risk assessment. Center for Medicare and Medicaid Innovation: Establishes the Center for Medicare and Medicaid Innovation (CMI) in CMS to test models of payment and delivery system models that reduce cost while maintaining or improving quality. Provides $1 billion/year for 10 years. Implementation: Center established by January 1, 2011. Medicare Premiums for Higher Income Beneficiaries: Freezes the income threshold for income-related Medicare Part B premiums for 2011 through 2019 at 2010 levels resulting in more people paying income-related premiums, and reduces the Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/couple. Community-Based Care Transitions Program: Five year community-based care transitions program to reduce readmission in PPS hospitals begins. Implementation: January 1, 2011-2016. Medicaid Payments for Hospitals Acquired Infections (HAI): Prohibits federal payments to states for Medicaid services related to certain hospital-acquired infections. Implementation: July 1, 2011. Medicaid Health Homes: Awards state planning grants for a new Medicaid state option to permit certain Medicaid enrollees to designate a provider as a health home. Provides states taking up the option with 90% federal matching payments for two years for health home-related services. Chronic Disease Prevention in Medicaid: Provides a 3-year grant to states to develop programs to provide Medicaid enrollees with incentives to participate in comprehensive health lifestyle programs and meet certain health behavior targets. Implementation: January 1, 2011. CLASS Program: Establishes a national voluntary insurance program for purchasing Community Living Assistance Services and Supports (CLASS program). National Quality Strategy: Requires the Secretary of the Department of Health and Human Services (DHHS) to develop and update annually a national quality improvement strategy that

	includes priorities to improve the delivery of health care services, patient heath outcomes and population health. Implementation: Initial strategy due to Congress by January 1, 2011. Grants to Establish Wellness Programs: Provides grants for up to five years to small employers that establish wellness programs. Authorizes funding beginning in FY 2011. Teaching Health Centers: Establishes Teaching Health Centers and provides payments for primary care residency programs in community-based ambulatory patient care centers. Implementation: Funding appropriated for five years beginning in FY 2011. Medical Malpractice Grants: Authorizes $50 million for five year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations. Implementation: Authorizes funding beginning FY 2011. Graduate Medical Education: Increases the number of Graduate Medical Education training positions by redistributing currently unused slots and promotes training in outpatient settings. Implementation: July 1, 2010. Medicare Independent Payment Advisory Board (IPAB): Establishes the 15-member IPAB to submit legislative proposals containing recommendations to reduce the per capital rate of growth in Medicare spending if spending exceeds targeted growth rates. Implementation: Funding available October 1, 2011; first recommendation due January 15, 2014. Medicaid Long Term Care Services: Creates the state Balancing Incentive Program in Medicaid to provide enhanced federal matching payment to increase non-institutionally based long-term care services and establishes the Community First Choice Option in Medicaid to provide community based attendant support services to certain disabled persons. Transition to ICD-10: ICD-9-CM crosswalk to ICD-10 due. Implementation: January 1, 2011. Deadline for all Medicare and Medicaid providers and suppliers to include national provider identifier on claims and enrollment applications. Implementation: January 1, 2011. Administrative Simplification: HHS Secretary shall adopt operating rules for electronic eligibility determinations for health plans and health claim status transactions. Implementation: July 1, 2011 and beyond.
2012	
	Medicare Provider Payment Rates: January 1, 2012 • MB-(0.1%+productivity) for OPPS • MB-1.0% for HHAs • MB-productivity for ASCs, dialysis, certain durable medical equipments (DME), ambulance • MB-(1.75%+productivity) for clinical labs • Revisions of practice expense geographic adjustment factor under PFS

- MA plan payment cut phase-in begins

July 1, 2012

- MB-(0.1%+productivity) for IPF

October 1, 2012

- MB-(0.1%+productivity) for IPPS, IRF, LTCH
- MB-productivity for SNF
- MB-(0.3%+productivity) for hospice through FY 2019(depending on number of insured individuals nationwide
- Year 2 geographic variation payments to hospitals in low-cost counties

Medicare Advantage Plan Payments: reduces rebates paid to Medicare Advantage plans and provides bonus payments to high-quality plans. Implementation: January 1, 2012.

Accountable Care Organizations: Allows providers that are organized as ACOs and voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. Implementation: No later than January 1, 2012.

Medicare Value Based Purchasing: Establishes a hospital value-based purchasing program (HVBP) in Medicare to pay hospitals based on performance on quality measures. 1.0% of IPPS MB is tied to HVBP; risk adjustment of HVBP quality outcome measures due. Requires plans to be developed to implement value-based purchasing programs for skilled nursing facilities, home health agencies and ambulatory surgical centers. Implementation: October 1, 2012.

Medicare Payment Reductions for Hospital Readmissions: Reduces Medicare payments that would otherwise be made to hospitals to account for excess (preventable) hospital readmissions. Maximum reduction to IPPS MB update under readmissions policy is 1%. Implementation: October 1, 2012.

Medicare Independence at Home Demonstration: Creates the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home. Implementation: January 1, 2012.

Data Collection to Reduce Health Care Disparities: Requires enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations. Implementation: March 23, 2012.

Medicaid Payment Demonstration Projects: Creates new demonstration projects in Medicaid for up to eight states to pay bundled payments for episodes of care that include hospitalizations and to allow pediatric medical providers organized as ACOs to share in cost savings. Implementation: January 11, 2012 through December 31, 2016.

Fraud and Abuse Prevention: Establishes procedures for screening, oversight, and reporting for providers and suppliers that participate in Medicare, Medicaid and CHIP, requires additional entities to register under Medicare.

Annual Fees on the Pharmaceutical Industry: Imposes new annual fees on the pharmaceutical

	manufacturing sector. Implementation: January 1, 2012.
2013	
	Medicare Provider Payment Rates: January 1, 2013 • MB-(0.1%+productivity) for OPPS • MB-1.0% for HHAs • MB-productivity for ASCs, dialysis, certain DME, ambulance • MB-(1.75%+productivity) for clinical labs July 1, 2013 • MB-(0.1%+productivity) for IPF • MB penalty (2%) for failure to report IPF quality measures. October 1, 2013 • MB-(0.3%+productivity) for IPPS, IRF, LTCH o 1.25% of IPPS MB update withheld for HVBP redistribution o MB penalty (2% for LTCHs, IRFs and Hospices that fail to report quality measures • MB-productivity for SNF • MB-(0.3%+productivity) for hospice through FY 2019(depending on number of insured individuals nationwide • Medicare DSH payment reductions begin; annually thereafter • $500 million in reductions to fund state allotments for Medicaid DSH based on HHS methodology. Medicaid Payments for Primary Care: Increases Medicaid payments for primary care services provided by primary care doctors to 100% of the Medicare payment rate for 2013 and 2014 (financed with 100% federal funding). Implementation: January 1, 2013 through December 31, 2014). Itemized Deductions for Medical Expenses: Increases the threshold for itemized deduction for unreimbursed medical expenses from 7.5% of AGI to 10% of AGI; waivers for individual age 65 and older for tax years through 2016. Flexible Spending Account Limits: limits the amount of contributions to FSA for medical expenses to $2,500 per years, COLA increase adjustment. Implementation: January 1, 2013. Medicare Tax Increase: Increases Medicare Part A tax rates on wages by 0.9% on earnings over $200,000 for individual; and $250,000 for married couples filing jointly and imposes a 3.8% assessment on unearned income for higher-income taxpayers, including sale of home. Implementation: January 1, 2013. Employer Retiree Coverage Subsidy: Eliminates tax-deduction for employers who receive Medicare part D retiree drug subsidy payments. Implementation: January 1, 2013. Tax on Medical Devices: Imposes an excise tax of 2.3% on the sale of any taxable medical device. Implementation: January 1, 2013.

	Medicare Bundled Payment Pilot Program: establishes a national Medicare pilot program to develop and evaluate making bundled payments for acute, inpatient hospital services, physician services outpatient hospitals services, and post acute care services for an episode of care. Implementation: January 1, 2013. Medicaid Coverage of Preventive Services: Provides a 1% increase in federal matching payments for preventive services in Medicaid for states that offer Medicaid coverage with non-patient cost-sharing for services recommended (rated A or B) by the USPSTF and recommended immunizations. Implementation: January 1, 2013. Closing the Medicare Drug Coverage Gap: Begins phasing in federal subsidies for brand name prescriptions filled in the Medicare Part D coverage gap (reducing coinsurance from 100% in 2010 to 25% in 2020, in addition to the 50% manufacturer brand name discount). Extension of CHIP: Extends authorization and funding for the Children's Heath Insurance program (CHIP) through 2015 (the current authorization is through 2013). Financial Disclosure: Requires the financial relationships between health entities, including physicians, hospitals, pharmacists other providers and manufacturers and distributors of covered drugs, devices, biologicals and medical supplies. Implementation: Report to Congress due April 1, 2013. CO-OP Health Insurance Plans: Creates the Consumer Operated and Oriented Plan (CO-OP) to foster the creation of non-profit member-run health insurance companies. Implementation: CO-OPs established by July 1, 2013.
2014	
	Medicare Provider Payment Rates. January 1, 2014 • MB-(0.3%+productivity) for OPPS • MB-productivity for ASCs, dialysis, certain DME, ambulance • MB-(1.75%+productivity) for clinical labs • Rebasing HHA payments begin with a 4-year phase-in period July 1, 2014 • MB-(0.3%+productivity) for IPF October 1, 2014 • MB-(0.2%+productivity) for IPPS, IRF, LTCH o 1.5% of IPPS MB update withheld for HVBP redistribution o 1.0% IPPS MB penalty applied for hospitals with HAI rates in top 25% nationally, annually thereafter. o 3% maximum reduction to IPPS MB update under readmissions policy. Four additional efficiency measures will be added. o MB penalty (2% for LTCHs, IRFs and Hospices that fail to report quality measures. • MB-productivity for SNF • MB-(0.3%+productivity) for hospice through FY 2019; potential for "give back." • Medicare DSH payment reductions continue

	• $600 million reduction to fund state allotments for Medicaid DSH based on HHS methodology. Medicare IPAB: IPAB must present proposals to the President and Congress to reduce cost growth and improve quality. IPPS hospitals are exempt until 2020. If IPAB fails to submit a proposal by January 15th, the Secretary must submit a proposal to Congress and the President. The PAB proposal is implemented automatically if Congress fails to act on a package without the required level of Medicare savings. Implementation: August 15, 2014. Expanded Medicaid Coverage: Expands Medicaid to all individuals not eligible for Medicare under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL: and provides enhanced federal matching payments for new eligibles. Implementation: January 1, 2014 (states have the option to expand coverage to childless adults beginning April 1, 2010). Presumptive eligibility for Medicaid: Allows all hospitals participating in Medicaid to make presumptive eligibility determinations for all Medicaid-eligible populations. Implementation: January 1, 2014.
2015	
	Medicare Provider Payment Rates January 1, 2015 • MB-(0.2%+productivity) for OPPS • MB-productivity for ASCs, dialysis, certain DME, ambulance • MB-(1.75%+productivity) for clinical labs • Rebased HHA payments continues phase-in period July 1, 2015 • MB-(0.2%+productivity) for IPF October 1, 2015 • MB-(0.2%+productivity) for IPPS, IRF, LTCH o 1.75% of IPPS MB update withheld for HVBP redistribution o 1.0% IPPS MB penalty applied for hospitals with Hospital Acquired Infections (HAC) rates in top 25% nationally, annually thereafter. o MB penalty (2% for LTCHs, IRFs and Hospices that fail to report quality measures. • MB-productivity for SNF • MB-(0.3%+productivity) for hospice; potential for "give back." • Medicare DSH payment reductions continue • $600 million reductions to fund state allotments for Medicaid DSH based on HHS methodology. IPAB Recommendations: IPAB must submit recommendations to Congress and the President on slowing growth in national health expenditures. Implementation: January 15, 2015. Increase in Federal match for CHIP: Provides for a 23% increase in the CHIP match rate up to a cap of 100%. Implementation: October 1, 2015 through 2015.

10-10

	Characteristics of Medicaid enrollees. States begin submitting an annual reporting on the number and characteristics of Medicaid enrollees, including estimates of the number of newly enrolled individuals. Implementation: January 1, 2015. State-based Exchanges: State exchanges have to be financially self-sustaining. Implementation: January 1, 2015.
2016	
	Medicare Provider Payment Rates January 1, 2016 • MB-(0.2%+productivity) for OPPS • MB-productivity for ASCs, dialysis, certain DME, ambulance, HHAs and clinical labs. • 2% penalty applied to PFS update for physicians who fail to submit PQRI measures successfully; annually thereafter. • Secretary must initiate separate programs to test VBP for LTCHs, IRFs, IPFs, PPS-exempt cancer hospitals and hospices. July 1, 2016 • MB-(0.2%+productivity) for IPF October 1, 2016 • MB-(0.75%+productivity) for IPPS, IRF, LTCH o 2% of IPPS MB update withheld for HVBP redistribution o 1.0% IPPS MB penalty applied for hospitals with Hospital Acquired Infections (HAC) rates in top 25% nationally, annually thereafter. o MB penalty (2% for LTCHs, IRFs and Hospices that fail to report quality measures. • MB-productivity for SNF • MB-(0.3%+productivity) for hospice; potential for "give back." • Medicare DSH payment reductions continue • $1.8 billion reductions to fund state allotments for Medicaid DSH based on HHS methodology. CHIP eligibles in Exchange: States may enroll CHIP eligible children in exchange-based qualified health plans if the children are denied CHIP coverage due to enrollment caps. Implementation: October 1, 2016. Health Care Choice Compacts: Permits states to form Health Care Choice Compacts and allows insurers to sell policies in any state participating in the compact. Implementation: January 1, 2016. Medicaid Demonstrations end: • States Medicaid health home demonstration ends December 31, 2016 • Medicaid bundled payment demonstration ends December 31, 2016 • Medicaid pediatric ACO demonstration ends December 31, 2016

2017	
	Medicare Provider Payments Rates January 1, 2017 • MB-(0.75%+productivity) for OPPS • MB-productivity for ASCs, dialysis, certain DME, ambulance, HHAs and clinical labs July 1, 2017 • MB-(0.75%+productivity) for IPF October 1, 2017 • MB-(0.75%+productivity) for IPPS, IRF, LTCH • MB-productivity for SNF • MB-(0.3%+productivity) for hospice; potential for "give back" • $5 billion in reductions to fund state allotments for Medicaid DSH based on HHS methodology.
2018	
	Medicare Provider Payment Rates January 1, 2018 • MB-(0.75%+productivity) for OPPS • MB-productivity for ASCs, dialysis, certain DME, ambulance, HHAs and clinical labs July 1, 2018 • MB-(0.75%+productivity) for IPF October 1, 2018 • MB-(0.75%+productivity) for IPPS, IRF, LTCH • MB-productivity for SNF • MB-(0.3%+productivity) for hospice; potential for "give back." • $5.6 billion in reductions to fund state allotments for Medicaid DSH based on HHS methodology. Tax on High Cost Insurance: Imposes an excise tax on insurers of employer-sponsored health plans with aggregate expenses that exceed $10, 200 for individual coverage and $27,500 for family coverage. Implementation: January 1, 2018. National Medicare Voluntary Bundled Payment Pilot ends December 31, 2018.
2019	
	Medicare Provider Payment Rates January 1, 2019 • MB-(0.75%+productivity) for OPPS • MB-productivity for ASCs, dialysis, certain DME, ambulance, HHAs and clinical labs July 1, 2019 • MB-(0.75%+productivity) for IPF October 1, 2019

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	• MB-productivity for IPPS, IRF, LTCH; annually thereafter. • MB-productivity for SNF • MB-(0.3%+productivity) for hospice; potential for "give back." • $4 billion in reductions to fund state allotments for Medicaid DSH based on HHS methodology. IPAB Proposal includes hospitals and hospice: First year IPAB proposal to reduce Medicare spending can include recommendations reduce hospitals or hospice payments. Implementation: September 1, 2019. Medicaid FMAP reductions. Medicaid FMAP for newly eligible enrollees (children, childless adults and parents is reduced to 93%. Implementation: January 1, 2019.
2020	
	Medicare Provider Payment Rates January 1, 2020 • MB-productivity) for OPPS, ASCs, dialysis, certain DME, ambulance, HHAs and clinical labs; annually thereafter July 1, 2020 • MB-productivity) for IPF; annually thereafter October 1, 2020 • MB-productivity for IPPS, IRF, LTCH; annually thereafter. • MB-productivity for hospice; annually thereafter.

Terms

Ambulatory Surgery Center (ASCs)
Children's Health Insurance Program (CHIP)
Community Living Assistance Services and Supports (CLASS program)
Consumer Operated and Oriented Plan (CO-OP)
Department of Health and Human Services (DHHS)
Disproportionate Share Hospital (DSH)
Durable Medical Equipment (DME)
Federally Qualified Health Centers (FQHCs)
Federal Poverty Limit (FPL)
Home Health Agency (HHA)
Hospital Acquired Infections (HAI)
Hospital Inpatient Prospective Payment System (IPPS)
Hospital Outpatient Prospective Payment System (OPPS)
Hospital Value-Based Purchasing Program (HVBP)
Independent Payment Advisory Board (IPAB)
Inpatient Rehabilitation Facilities (IRF)
Long Term Care Hospitals (LTCH),
Market Basket (MB)
National Health Service Corps (NHSC)
Patient-Centered Outcomes Research Institute (PCORI)
Psychiatric Hospitals (IPF)
National Health Service Corps (NHSC)
Recovery Audit Contractor (RAC)
Skilled Nursing Facility (SNF)
U.S. Preventive Services Task Force (USPSTF)

Polsinelli Shughart PC

Highlights

Patient Protection and Affordable Care Act (P.L. 111-148) (Signed into law on March 23, 2010), as amended by Health Care and Education Reconciliation Act (P.L. 111-152) (Signed into law on March 30, 2010)

Pilots, Demonstrations and Grants

Name of Project/Grant	Eligibility /Description
Establishment of Center for Medicare and Medicaid Innovation within CMS ACA - 3021, 10306	New Federal Agency The law creates the Center for Medicare and Medicaid Innovation within CMS to research, develop, test and expand innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals.
Medicare Shared Savings Program (Accountable Care Organizations) ACA - 3022, 10307	Eligibility: Groups of providers and suppliers that have established a mechanism for shared governance and meet standards established by HHS Creates a shared savings program that promotes accountability for a patient population and coordinates items and services under Medicare Parts A and B and investment in new processes to bring about high quality and efficient service. The accountable care organization (ACO) must become accountable for the quality, cost and overall care of the Medicare fee for service (FFS) beneficiaries assigned to it. The ACO must include primary care professionals that are sufficient for the number of FFS beneficiaries assigned. At a minimum, the ACO shall have at least 5,000 beneficiaries in order to be eligible.
Medicaid Pediatric Accountable Care Organization Demonstration Project	Eligibility: States, pediatric medical care providers Establishes a demonstration project for states, which would allow pediatric medical providers who meet certain criteria to be recognized as ACOs for purposes of receiving incentive payments.

Name of Project/Grant	Eligibility /Description
ACA - 2706	*Such sums as necessary authorized.*
National Pilot Program on Payment Bundling (Medicare) ACA - 3023	Eligibility: Hospitals, physicians groups, skilled nursing facilities and home health agencies The Secretary will develop a national voluntary pilot program encouraging hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models for 10 conditions *No additional funds authorized.*
Medicaid Demonstration to Evaluate Integrated Care Around Hospitalization ACA - 2704	Eligibility: Up to 8 States The Secretary must establish a demonstration project to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary with respect to an episode of care that includes a hospitalization, and for concurrent physician services provided during a hospitalization. The demonstration project begins on January 1, 2012, and ends on December 31, 2016. *No additional funds authorized.*
Medicaid Global Payment System Demonstration Project ACA - 2705	Eligibility: Limited to 5 States; safety net hospital system/network A participating state shall adjust the payments made to an eligible safety net hospital system or network from a fee-for-service payment structure to a global capitated payment model. *Such sums as necessary authorized.*
Extension of Demonstration Projects for Dual-Eligibles ACA- 2601	Eligibility: States Medical assistance programs for dual-eligibles operating under a waiver may be conducted for 5 years and, upon request of the State, maybe extended for additional 5-year periods.
Medicaid Emergency Psychiatric Demonstration ACA - 2707	Eligibility: States, Institutions for Mental Disease Under the project, states shall reimburse certain institutions for mental disease for services provided to Medicaid beneficiaries for medical assistance to stabilize an emergency psychiatric condition. *$75 Million appropriated for FY 2011. These funds available through December 31, 2015.*
Medicare Demonstration Program ACA - 3024	Eligibility: Medical practice of physicians or nurse practitioners that provides care as part of a team Program tests the use of home-based primary care teams for chronically ill Medicare beneficiaries in an effort to reduce expenditures and improve health outcomes. The project will test the reduction of expenditures and improvement in health by implementing physician and nurse

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Name of Project/Grant	Eligibility /Description
	practitioner-directed, home-based primary care teams.
Extension of Medicare Gainsharing Demonstration ACA - 3027	Eligibility: Hospitals, physicians The gainsharing demonstration project set to end on December 31, 2009, has been extended until September 30, 2011, for projects in operation as of October 1, 2008. *Appropriates an additional $1.6 million for FY 2010.*
Extension of the Rural Community Hospital Demonstration Program ACA - 3123, 10313	Eligibility: Hospitals The law extends the Rural Community Hospital Demonstration Program for five more years (through 2014) and expands eligible sites to 20 states and 30 rural hospitals. Hospitals in the program are required to have fewer than 51 acute care hospital beds (not counting beds in distinct-part psychiatric or rehabilitation units), make available 24-hour emergency care services, and not be designated as critical access hospitals. The new law has no effect on rural community hospitals currently participating in the demonstration program; they may continue to participate unless they elect to opt out.
Extension of Medicare Rural Hospital Flexibility Program ACA - 3129	Eligibility: States, rural hospitals Extends HRSA's Flex Grant program through 2012 and allows flex grant funding to be used to support rural hospitals' efforts to implement delivery system reform programs, such as value-based purchasing programs, accountable care organizations, bundling, and other quality programs. *Authorizes funds as may be necessary for FY 2011 and FY 2012.*
Pay-for-Performance Pilot for Certain Medicare Providers ACA - 10326	Eligibility: IRFs, LTCHs, hospice, psychiatric hospitals, PPS-exempt cancer hospitals Provides the Secretary with the authority to test value-based purchasing programs for inpatient rehabilitation facilities, inpatient psychiatric hospitals, long-term care hospitals, certain cancer hospitals and hospice providers by no later than January 1, 2016.
Demonstration on Access to Affordable Care ACA - 10504	Eligibility: State-based nonprofit public private partnerships. (Up to 10 states) The Secretary is directed to establish a three-year demonstration project through the Health Resources and Services Administration to test the provision of access to comprehensive health care services to the uninsured at reduced fees. The demonstration grants will be made to entities in up to 10 states. *Authorizes such sums as necessary.*
State Option to Provide Health Homes for Medicaid	Eligibility: States States have the option of enrolling Medicaid beneficiaries with chronic conditions into a health home, which will include a

Name of Project/Grant	Eligibility /Description
Enrollees With Chronic Conditions ACA - 2703	team of health professionals and provide a comprehensive set of medical services, including care coordination. Beginning January 1, 2011, the Secretary may award planning grants to states for the purpose of developing a state plan amendment with respect to health homes for eligible individuals with chronic conditions.
Money Follows the Person Rebalancing Demonstration (Medicaid) ACA - 2403	Eligibility: Community-based services, States The Money Follows the Person Rebalancing Demonstration is extended through September 30, 2016. The Secretary is authorized to award grants to states on a competitive basis to help states transition Medicaid-eligible individuals from long-term institutional care to community-based long-term care.
Community Based Care Transitions Program (Medicare) ACA - 3026	Eligibility: Hospitals, Community-based entities that provide transition services Funding is provided to hospitals and community-based entities that furnish evidence-based care transition services to Medicare beneficiaries who are at high risk for readmission. In selecting eligible entities, priority must be given to eligible entities that participate in a program administered by the Administration on Aging that provides concurrent care transition interventions with multiple hospitals and practitioners, or those that provide medically under served populations, small communities and rural areas. *Appropriates $500 million for FY 2011 – 2015.*
Improvements to the Demonstration Project on Community Health Integration Models in Certain Rural Counties ACA - 3126	Eligibility: Critical Access Hospitals, physicians The rural counties demonstration project on community health integration models is expanded to allow additional counties and physicians to participate. *Appropriates $500 million for FY 2011- 2015.*
Medicare Hospice Concurrent Care Demonstration ACA - 3140	Eligibility: Hospice A three-year Medicare Hospice Concurrent Care demonstration program will be established at participating hospice programs under which Medicare beneficiaries are furnished, during the same period, hospice care and any other items or services covered under Medicare. Fifteen hospices including both urban and rural locations would be selected for the program.
Healthcare Delivery System Research, Quality Improvement Technical	Eligibility: National, state, multi-state, multi-site quality improvement networks; providers and organizations meeting certain criteria. Establishes the Center for Quality Improvement and Patient Safety in the Agency for Healthcare Research and Quality. The

Name of Project/Grant	Eligibility /Description
Assistance ACA - 3501	Center will support research on health delivery system improvement and development of tools to facilitate adoption of best practices. Technical assistance grants and contracts will enable eligible entities to provide technical support to health care institutions and providers. Implementation grants and contracts will be awarded to eligible hospitals and other providers. *The Center is appropriated $20 million for FY 2010 – 2014.*
Medication Management Services and Treatment of Chronic Disease ACA – 3503	Eligibility: Licensed Pharmacists The Secretary will establish a program to provide grants or contracts to implement medication management services provided by licensed pharmacists.
Design and Implementation of Regionalized Systems for Emergency Care ACA - 3504	Eligibility: State, local governments The law provides funding to the Assistant Secretary for Preparedness and Response to support pilot projects that design, implement and evaluate innovative models of regionalized, comprehensive and accountable emergency care in trauma systems that coordinate with public safety services, public health services, emergency medical services, medical facilities and other entities within a region including 911 and emergency medical dispatch. The Secretary may not award a grant unless the state or states agree to share the costs. The States must pay not less than $1 for each $3 of federal funds in cash or in kind. In addition, the Secretary must give priority for grants to any eligible entity that serves a population in a medically underserved area. *Authorizes such sums as necessary for FY 2010 – FY 2014.*
Trauma Care Centers and Service Availability ACA – 3505	Eligibility: States, Qualified public, non-profit Indian Health Service, Indian tribal and urban Indian trauma centers Establishes three programs to award grants to: (1) assist in defraying substantial uncompensated care costs; (2) further core missions of trauma centers; and (3) provide up to four years of emergency relief to ensure continued and future availability of trauma services. *Authorizes to be appropriated $100 million in fiscal year 2009 and such sums as may be necessary for fiscal years 2010 through 2015.* HHS is required to provide funding to states to enable them to award grants to eligible entities for the purpose of promoting universal access to trauma care services provided by trauma centers and trauma-related physician specialties. Each state may award grants to eligible entities – defined as public or non-profit trauma centers; safety-net public or nonprofit trauma centers or hospitals in underserved areas – that seek to undertake specified activities that support trauma care services in the state.

Name of Project/Grant	Eligibility /Description
	Authorizes to be appropriated $100 million for each of fiscal years 2010-2015.
Demonstration Program to Integrate Quality Improvement of Patient Safety Training Into Clinical Education of Health Professionals ACA - 3508	Eligibility: Health professions schools, schools of public health, schools of social work, schools of nursing, schools of pharmacy, institutions with graduate medical education programs, or schools of health care administration Establishes a program at Agency for Health Research and Quality (AHRQ) to give grants to academic institutions to develop and implement academic curricula that integrate quality improvement and patient safety into health professionals' clinical education.
Patient Navigator Program ACA - 3510	Eligibility: Rural health clinics, academic medical centers The patient navigator program, which assists patients in overcoming obstacles to the prompt diagnosis and treatment of health problems, is extended through the end of fiscal year 2015. The program will award grants to eligible entities for the development and operation of demonstration programs to provide patient navigator services in order to improve health care outcomes. Patient navigators assist individuals by identifying sources of care and insurance, coordinating referrals, and facilitating enrollment in clinical trials. The program also assists community organizations in helping individuals to receive better access to care and conducts outreach to "health disparity populations." *Authorizes $3,500,000 for fiscal year 2010 and such funds as necessary for FY 2011 – 2015.*
Incentives/Grants for Prevention of Chronic Diseases in Medicaid ACA - 4108	Eligibility: Medicaid providers, community-based organizations, faith-based organizations, public-private partnerships, Indian tribes or other organizations Grants will be available for demonstration projects to test the use of evidence-based incentives for Medicaid beneficiaries to prevent chronic diseases. Participating beneficiaries will be required to adopt and maintain healthy behaviors and achieve one or more of five specific goals: smoking cessation, weight reduction or control, lowering blood pressure, lowering cholesterol and avoiding the onset, or improving the management of, diabetes. *Authorizes such sums as necessary for each fiscal year from 2010 – 2014.*
Community Transformation Grants ACA - 4201	Eligibility: State and local governments, agencies, national network of community-based organizations, state/local non-profits, Indian tribes Authorizes the HHS Secretary to award competitive grants, from fiscal years 2010 through 2014, to eligible entities for evidence-based community preventive health activities to improve individual and community health, reduce the incidence of chronic disease, create healthier school environments and reduce racial and ethnic disparities. Communities can carry out programs to prevent and reduce the incidence of chronic diseases associated with obesity, tobacco use, or mental illness, and/or other activities that are consistent with the goals of promoting healthy communities.

Name of Project/Grant	Eligibility/Description
	Authorizes such sums as necessary for each fiscal year 2010 through 2014.
Healthy Aging, Living Well Grants (Medicare) ACA - 4202	Eligibility: State and local health departments, Indian tribes Authorizes HHS, acting through the CDC, to award grants (fiscal years 2010 through 2014) for pilot programs designed to improve the health of individuals 55 to 64 years of age through community-based public health interventions. Intervention activities may include efforts to improve nutrition, increase physical activity, reduce tobacco use and substance abuse, improve mental health, and promote healthy lifestyles among the target population. Grants should also be used to conduct ongoing health screening to identify risk factors for cardiovascular disease, cancer, stroke and diabetes among individuals in both urban and rural areas who are between 55 and 64 years of age and refer at-risk individuals for treatment or follow up care. *Authorizes to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014.* The Secretary shall conduct an evaluation of community-based prevention and wellness programs and develop a plan for promoting healthy lifestyles and chronic disease self-management for Medicare beneficiaries. *Appropriates $50 million to be used for this purpose.*
Immunizations Demonstration ACA - 4204	Eligibility: States CDC will provide grants to states to improve immunization coverage of children, adolescents and adults through the use of evidence-based, population-based interventions for high-risk populations.
Individualized Wellness Plan Demonstration ACA - 4206	Eligibility: Community health centers (10) Provides at-risk populations who utilize community health centers with a comprehensive risk-factor assessment and an individualized wellness plan designed to reduce risk factors for preventable conditions. The goal of the program is to test the impact of wellness plans on reducing the risk factors. *Authorizes such sums as may be necessary.*
Epidemiology – Lab-Capacity Grants **ACA - 4304**	Eligibility: State and local health departments, academic centers Grants will be awarded to assist public health agencies with improving surveillance for, and response to, infectious diseases and other conditions of public health importance. *Authorizes $190 million for each fiscal year from FY 2010 – 2013.*
Childhood Obesity (Medicaid, CHIP)	Eligibility: States Appropriates $25 million for fiscal years 2010 through 2014 to extend the childhood obesity demonstration established in the

Name of Project/Grant	Eligibility /Description
ACA - 4306	Children's Health Insurance Program Reauthorization Act of 2009 and designed to improve the quality of care under Medicaid and CHIP.
Grants to Nurse-Managed Health Clinics ACA - 5208	Eligibility: Nurse-managed health clinics The Secretary will award grants for operating nurse-managed health clinics that satisfy certain criteria. *Authorizes $50 million for FY 2010 and such sums as necessary for FY 2010 – FY 2014.*
National Independent Monitor Demonstration Project ACA - 6112	Eligibility: Skilled nursing facilities (SNFs), nursing facilities (NF) HHS will conduct a pilot program to develop, test, and implement use of an independent monitor to oversee interstate and large intrastate SNF and NF chains for two years, and within one year of enactment.
Nursing Home Demonstration on Information Technology Usage and Culture Change ACA - 6114	Eligibility: Nursing facilities HHS will conduct two facility-based demonstration projects, for a period not to exceed three years, and within one year of enactment, that will develop: (1) "culture change" best practices, and (2) information technology best practices.
Program Integrity ACA - 6703	Eligibility: Skilled nursing facilities, nursing facilities HHS will make grants to state agencies that perform surveys of SNFs and NFs under Social Security Act Secs. 1819 and 1919 for the purpose of designing and implementing complaint investigation systems.
Community-Based Collaborative Care Networks ACA - 10333	Eligibility: Consortia of providers with joint governance structures, DSH hospitals and federally qualified health centers (FQHCs) Provides assistance to minority populations through grant funding to community-based collaborative care networks that provide comprehensive, coordinated and integrated health care services to low-income populations. Funds must be used to support efforts to help low-income individuals access appropriate services, enroll in health coverage programs and obtain a regular primary care provider or medical home. Funds also can be used to provide case management and care management, perform health outreach, provide transportation, and expand capacity through such approaches as telehealth, after-hours services or urgent care, and other direct patient care services. *Authorizes such funds as necessary for each fiscal year 2011 through 2015.*
Establishing Community Health Teams to Support the Patient-Centered Medical	Eligibility: State or State-designated entities Establishes a program of grants and contracts for community-based, interdisciplinary, inter-professional health teams to

Name of Project/Grant	Eligibility /Description
Home ACA - 3502	support services and provide capitated payments to primary care providers, including obstetrics and gynecology practices, in hospital service areas served by eligible entities. Primary care providers in the program furnish integrated, accessible health care services, and are accountable for addressing a substantial number of personal health care needs while practicing in the context of family and community.
State Health Care Workforce Development Grants ACA - 5102	Eligibility: State workforce investment boards Establishes competitive grants beginning in fiscal year 2010 for the purpose of enabling state partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the state and local levels. Grants will support innovative approaches to increase the number of skilled health care workers such as health care career pathways for young people and adults.
Enhancing Health Care Workforce Education and Training Grants ACA - 5301	Eligibility: Hospitals, medical schools, academically-affiliated physician assistant training programs, non-profit entities. The Secretary may award grants or contracts to support and develop professional training programs in the field of family medicine, general internal medicine, or general pediatrics for medical students, interns, residents, or practicing physicians. *Authorizes $125 million for FY 2010 and such sums as necessary for FY 2011 – 2014.*
Training Opportunities for Direct Care Workers Grant Program ACA - 5302	Eligibility: Institutions of higher education partnering with SNFs, or other entities providing long-term care of home and community-based services Supports new training opportunities for eligible direct care workers employed in long-term care settings, including individuals who agree to work in the fields of geriatrics, disability services or chronic care management. *Authorizes $10 million for fiscal years 2011 through 2013.*
Geriatric Education and Training Grants ACA - 5305	Eligibility: Geriatric education centers and various non-facility health care providers *Authorizes a variety of grants and awards, including $10.8 million in grants for fiscal years 2011 through 2014 to create not more than 24 geriatric education centers and $10 million in awards for fiscal years 2011 through 2013 to health professionals to foster greater interest in the field of geriatrics, long-term care and or chronic care management.*
Advanced Nursing Education Grants ACA - 5308	Eligibility: Nurse midwife The advanced nursing education grant program is modified to strengthen requirements for nurse midwifery grants by requiring eligible programs to be accredited by the American College of Nurse-Midwives Accreditation Commission for Midwifery Education. The cap on doctorate degree traineeship programs is eliminated.

Name of Project/Grant	Eligibility /Description
Nurse Education, Practice, and Retention Grants ACA - 5309	Eligibility: Nursing schools, health care facilities Authorizes nurse retention grants for fiscal years 2010 through 2012. The grants must be used to: 1) promote career advancement for individuals (including licensed practical nurses and other members of the health care workforce) to become baccalaureate-prepared registered nurses or advanced practice nurses; 2) to develop and implement internships and residency programs to encourage mentoring and the development of nursing specialties; or 3) to provide individuals with the education and training necessary to enter the nursing profession and advance within the profession. *Authorizes such funds as may be necessary for FY 2010 – 2012.*
Community Health Workforce Promotion Grants ACA - 5313	Eligibility: Public or non-profit private entities (including a state or public subdivision of a state, a public health department, a free health clinic, a hospital, or a federally-qualified health center), or a consortium of any such entities Authorizes the HHS Secretary and the CDC Director to award grants to promote positive health behaviors and outcomes in medically underserved areas through the use of community health workers. Grants will be used to support community health workers who help connect underserved populations with the most appropriate services at the most appropriate time. Priority will be given to geographic areas with a high percentage of uninsured or underinsured residents, those with a high percentage of chronic disease, or those with a high infant mortality rate. *Authorizes the program for fiscal years 2010 through 2014.*
Family Nurse Practitioner Training Program Grants ACA – 5316, 10501	Eligibility: FQHCs, nurse-managed health clinics The grants provide new nurse practitioners with clinical training to enable them to serve as primary care providers in FQHCs and nurse-managed health clinics (NMHC) and will help create a model of FQHC and NMHC training for nurse practitioners that may be replicated nationwide. *Authorizes such sums as necessary for FY 2011- FY 2014.*
Centers of Excellence Grants ACA - 5401	Eligibility: Designated health professions schools and other public and nonprofit health or educational entities Continues to provide grants to designated health professions schools and other public and nonprofit health or educational entities for the purpose of assisting the schools that are supporting programs of excellence in health professions education for under-represented minority individuals. *Authorizes $50 million for each fiscal year 2010 – 2015 and such sums as necessary for each subsequent fiscal year.*
Workforce Diversity Grants ACA - 5404	Eligibility: Schools of nursing, nursing centers, academic health centers, state or local governments Expands allowable uses of nursing diversity grants to include completion of associate degrees, bridge or degree completion program, or advanced degrees in nursing, as well as pre-entry preparation, advanced education preparation, and retention

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Name of Project/Grant	Eligibility /Description
	activities.
Primary Care Extension Program ACA - 5405	Eligibility: States The Secretary is authorized to award competitive grants to states for the establishment of state- or multistate-level Primary Care Extension Program State Hubs.
Demonstration to Address Health Professions Workforce Needs ACA - 5507	Eligibility: States, Indian tribes, institutions of higher education, local workforce investment boards, sponsors of apprenticeship programs, community-based organizations Competitive grants will be used to provide aid and supportive services to low-income individuals and the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to experience labor shortages or be in high demand. The demonstration grant is to serve low-income persons including recipients of assistance under State Temporary Assistance for Needy Families (TANF) programs. Grants will be awarded within 18 months.
Teaching Health Centers Development Grants ACA - 5508	Eligibility: Teaching health centers. Defined as FQHCs, community mental health centers, rural health clinics, and health centers operated by the Indian Health Service Directs the HHS Secretary to establish a grant program to support new or expanded primary care residency programs at teaching health centers. *Authorizes $25 million for fiscal year 2010, $50 million for fiscal years 2011 and 2012, and such sums as may be necessary for each fiscal year thereafter to carry out such program.* Provides funding under the Public Health Service Act to cover the indirect and direct expenses of qualifying teaching health centers related to training primary care residents in certain expanded or new programs. *Appropriates such sums as may be necessary, not to exceed $230,000,000, for the period of fiscal years 2011 through 2015.*
Graduate Nurse Education Demonstration ACA - 5509	Eligibility: Hospitals meeting certain criteria Five eligible hospitals may receive payment for reasonable costs of qualified clinical training to advance practice nurses. *Appropriates $50 million for each fiscal year for FY 2012 – 2015.*
State Grants to Health Care Providers Caring for Medically-Underserved Populations ACA - 5606	Eligibility: Providers treating medically underserved populations A State may award grants to health care providers who treat a high percentage, as determined by such state, of medically underserved populations or other special populations in such state. *Appropriates $4 million for each fiscal year FY 2010 – 2013.*

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Name of Project/Grant	Eligibility /Description
Preventive Medicine and Public Health Training Grant Program AC A - 10501	Eligibility: Schools, hospitals, state, local and tribal health departments Grants for graduate medical education will be provided to eligible entities to provide training to graduate medical residents in preventive medicine specialties. *Authorizes $43 million for FY 2011 and such sums as necessary for FY 2012 through FY 2015.*
State Medical Tort Litigation Alternatives Demonstration ACA - 10607	Eligibility: States Authorizes $50 million in demonstration grants to States to test alternatives to civil tort litigation. These models will be required to emphasize patient safety, the disclosure of health care errors, and the early resolution of disputes. Patients will be able to opt-out of these alternatives at any time.

10425.1

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid, CHIP and Survey & Certification
Family and Children's Health Programs Group

October 13, 2010

Barbara Langner, Ph.D.
Medicaid Director
Kansas Health Policy Authority
Room 900-N, Landon Building
900 S.W. Jackson Street
Topeka, KS 66612-1220

Dear Dr. Langner:

This letter is in regard to Kansas' ninth Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) request of May 27, 2010. The SPA is seeking authority to increase monthly premiums that beneficiaries or their families must pay as a condition for CHIP coverage, effective July 1, 2010. We are concerned that the SPA could trigger a number of consequences, including loss of Medicaid funding.

The Patient Protection and Affordable Care Act of 2010 (the Affordable Care Act) provides additional resources to the States to pay for health services for children and low-income working families. To ensure that these additional resources achieve the intended purposes and do not simply replace State resources that are shifted to other priorities, the statute contains "maintenance of effort" (MOE) provisions that condition Medicaid funding on the State not adopting "eligibility standards, methodologies or procedures" for Medicaid and CHIP eligibility that are more restrictive than those in effect on the date of enactment of the Affordable Care Act. On June 25, 2010, CMS held a conference call with Kansas during which we informed you that the State's request to implement premium increases may be a violation of the MOE provisions. We reiterated this concern during a September 23, 2010, call with you.

We want you to be aware that it appears that your SPA triggers the MOE provisions in the Affordable Care Act relating to the CHIP program. The increased premium requirement is a more restrictive "eligibility methodology, standard or procedure," since payment of the increased premium is a condition of initial or continued eligibility for coverage. Therefore, your request could result in a loss of Medicaid funding for Kansas under section 2105(d)(3) of the Social Security Act, as amended by sections 2101 and 10203 of the Affordable Care Act. Kansas currently receives about $34.7 billion in Federal Medicaid funding per year and this funding is potentially at risk if Kansas raises premiums for enrollees in the CHIP program as described in its ninth CHIP amendment.

To be certain that the State is informed of this possibility, we are asking Kansas to confirm that the State intends for CMS to continue with its review of this CHIP SPA. If you do choose to proceed with the proposed increase in premiums in light of the above information, please provide a copy of the State law authorizing the increased premium, and the prior public notice of the premium increase, so our review of your request may proceed. If you choose not to pursue this option, please indicate if the State will choose to withdraw the SPA currently under consideration. The State has already taken up the option of removing certain other proposals from SPA #9 (and including them in a separate SPA #10, which is currently under review and would not be affected by withdrawal of SPA #9).

Under section 2106(c) of the Social Security Act, CMS must approve, disapprove or request additional information on an amendment to a title XXI State plan within 90 days. On August 27, 2010, CMS stopped the 90-day review period for your CHIP SPA #9, and it will resume as soon as a response to the concerns described in this letter is received. The members of the review team are available to answer any questions you may have in regard to this letter and to assist your staff in formulating a response.

Please send your response electronically, as well as in hard copy to Ms. Terri Murphy, project officer for the Kansas title XXI proposal, with a copy to the CMS Region VII Office. Ms. Murphy's E-mail address is Terri.murphy@cms.hhs.gov. Her mailing address is:

Centers for Medicare and Medicaid Services
Center for Medicaid, CHIP and Survey & Certification
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, Maryland 21244-1850

You may contact me at 410-786-5143 if you have questions or need clarification.

Sincerely,

Linda Nablo

Linda Nablo
Director
Division of State Children's Health Insurance

cc: Mr. James Scott, Associate Regional Administrator, Region VII

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KANSAS HEALTH POLICY AUTHORITY

Joint Committee on Health Policy Oversight
Kansas Medicaid Health Information Technology Initiative Update

November 4-5, 2010

Andy Allison
Executive Director
Kansas Health Policy Authority

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JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT

DATE: 11-5-10
ATTACHMENT: 13

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KANSAS HEALTH POLICY AUTHORITY

The American Recovery and Reinvestment Act of 2009 (ARRA) health information technology (HIT) provisions afford Kansas and Medicaid providers with an opportunity to leverage Federal funding of provider incentive payments, planning efforts, and Medicaid information systems development. These funds are for the development and "meaningful use" of electronic health record (EHR) technology and health information exchange (HIE) to improve patient care throughout the State.

The Kansas Health Policy Authority (KHPA), as the designated State Medicaid Agency, will develop and submit to the Center for Medicare and Medicaid Services (CMS) a Medicaid HIT vision document, referred to as the State Medicaid HIT Plan (SMHP), describing the role of the Medicaid program in the state's overall plan to advance and achieve meaningful use of electronic health information.

KHPA participated actively in the development of the statewide HIE plan, i.e., the "Strategic and Operational Plan," which is under review by the Federal government. The statewide HIE plan has now been handed to the recently-convened Kansas Health Information Exchange (KHIE) for implementation. The KHIE is a public-private partnership established by Executive Order and charged with overseeing federally-sanctioned HIE efforts in the state. KHPA sits on the KHIE Board of Directors and will work with the state HIE coordinator, the KHIE, and a wide range of Medicaid stakeholders to complete and then implement the SMHP.

American Recovery and Reinvestment Act (ARRA) HIT Requirements for States:

Included in ARRA is **$19.2 Billion** that is intended to be used to increase the use of Electronic Health Records **(EHR)** by physicians and hospitals. Funding is designated for both providers (in the form of incentive payments for those who have successfully implemented HIT and have used HIE meaningfully) and for states (in the form of planning and implementation grants). These provisions of the bill are called the Health Information Technology for Economic and Clinical Health Act, or HITECH Act.

Determining Policies and Standards

Located within the Department of HHS is the Office of the National Coordinator for Health Information Technology (ONCHIT). Created by Executive Order in 2004, it was legislatively mandated in the ARRA. Through the HITECH Act, the ONC was to adopt an initial set of HIT standards, and create an incentive program for meaningful users of EHR certified technology.

Final Rule for Meaningful Use

Under the HITECH Act of 2009, eligible health care professionals and hospitals can qualify for Medicare and Medicaid incentive payments when they adopt certified EHR technology and use it to achieve specified objectives. One of the two regulations, announced by ONC on July 13, 2010, defines the above "meaningful use" objectives that providers must meet to qualify for the bonus payments. The other regulation identifies the technical capabilities required for certified EHR technology. See details regarding the three phases of meaningful use

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below.

Consideration of Medicaid in HITECH

The provisions in HITECH, and the federal guidance that has been issued since the bill was passed, envision an important role for the Medicaid program in state-level planning and implementation. Requirements of the ARRA State Grants to Promote Health Information Technology include:

- States will be expected to use their authority, programs, and resources to:
  - Convene health care stakeholders to ensure trust in and support for a statewide approach to HIE.
  - Coordinate an integrated approach with Medicaid and state public health programs to enable information exchange and support monitoring of provider participation in HIE as required for Medicaid meaningful use incentives.

- "...recipients are required to submit, as part of the strategic or operational plan to ONC, a plan that indicates how recipients will align with the State Medicaid HIT Plan (SMHP). The recipient must also confirm that the State Medicaid Director (SMD) approves Medicaid content in the HIE Strategic and Operational Plans as a required sign-off. Additionally, recipients are required to submit as part of the strategic or operational plan to ONC a plan that indicates how recipients will align with and leverage as appropriate the Public Health agency's existing initiatives and future plans."

CMS' Phased Approach to Meaningful Use of electronic health information:

CMS has identified three sets of thresholds in a phased approach to the nationwide adoption and meaningful use of EHRs and HIE:

- Stage 1: Capture Data in a Coded Format (2011)
  The Stage 1 meaningful use criteria focus on:
  - Electronically capturing health information in a coded format in the clinical setting;
  - Using that information to track key clinical conditions and communicating that information for care coordination purposes in structured format whenever feasible; and,
  - Implementing clinical decision support tools to facilitate disease and medication management, and reporting clinical quality measures and public health information.

- Stage 2: Expand upon the Stage 1 Criteria (2012)
  Stage 2 expands upon the Stage 1 criteria in the areas of disease management, clinical decision support, medication management, support for patient access to their health information, transitions in care, quality measurement and research, and bi-directional communication with public health agencies.

- Stage 3: Achieve Improvements in Quality, Safety and Efficiency (Timeframe not yet defined)

KHPA Goals for HIT and HIE:

KHPA's overall mission in the area of HIT and HIE is to promote and achieve widespread adoption and meaningful use of HIT, with an emphasis on the use of this technology to exchange health information, improve health care delivery, and implement a medical home for all Medicaid recipients, using Kansas Medicaid providers as an effective way to encourage HIT adoption and use for these purposes. Because the Kansas Medicaid program currently covers nearly 14.9% of the Kansas population, and will grow significantly following implementation of coverage expansions in 2014, Medicaid can play a key role in supporting widespread HIT adoption in Kansas. The agency's initial emphasis in this area is to support rapid adoption of HIT by providers through the federally-funded Medicaid incentive payment program, which provides core Medicaid providers as much as $67,500 over six years . [See ATTACHMENT 1 for a schedule of provider incentives for high-volume Medicaid providers:]

A second emphasis for KHPA is to ensure that health information technology is used to benefit Medicaid beneficiaries. To qualify for federally-funded Medicaid incentive funds, federal regulations require providers to demonstrate they are making

"meaningful use" of health information technology. One of the shortcomings in this standard is that it only requires compliance for a portion of the provider's total patient base. In most medical practices, Medicaid beneficiaries make up only a small fraction of the provider's business, so providers need not achieve meaningful use of electronic health information on their behalf in order to receive Medicaid provider incentives. Of course, we're confident that providers will make every effort to treat all of their patients with the same high standards, but Medicaid beneficiaries face obstacles that could leave them less well-served by HIT and HIE. Medicaid beneficiaries are least likely to have a stable relationship with a provider, and are often most in need of the benefits that HIT and HIE have to offer, such as care management and coordination across multiple providers. As noted above, the federal guidelines anticipate full deployment of HIT and HIE as a staged process over a period of years. In the later stages, there will be a need for greater integration between Medicaid and the state information exchange in order to ensure that all Kansans receive the expected benefits.

In addition to the partners and stakeholders included in the Statewide HIE effort, KHPA convened in August a Kansas HIT Medicaid Stakeholder Group to solicit input on the projects and Medicaid goals related to this effort. With input from the Kansas HIT Medicaid Stakeholder Group, KHPA has established the following HIE goals for the Medicaid program in Kansas:

- Utilize the HIE to measure meaningful use;
- Utilize the HIE to gather data needed to document and measure qualification for Medicaid incentive payments;
- Utilize the HIE as needed to gather data and fill gaps in order to compute quality measures and to help manage and coordinate care to ensure meaningful use for Medicaid beneficiaries – regardless of their connection to a primary care medical home; and,
- Utilize the HIE to facilitate a Medical Home and patient centered care for each individual.

Additional goals of the SMHP will include:

- Exploring opportunities to maximize care coordination through financial and non-financial incentives; and
- Identifying state agencies' investments that might be leveraged including Medicaid eligibility system, MMIS, and others in addition to Medicaid.

State Medicaid HIT Plan (SMHP):

The SMHP will build upon the statewide plan for HIE which was developed under the leadership of the Kansas Department of Health and Environment (KDHE).

The SMHP will be designed to enable Medicaid providers and KHPA to achieve the goals outlined above. CMS and the Office of the National Coordinator for Health Information Technology (ONC) will review the SMHP and determine what activities are eligible for the Recovery Act HIT Federal financial participation (FFP). The SMHP is to include, at a minimum:

- A Current Technology Landscape Assessment - the extent of HIT and HIE activities currently underway within the Medicaid enterprise (including but not limited to Electronic Health Record (EHR) technology adoption),
- A Vision of the State's Medicaid HIT Future,
- Specific Actions Necessary to Implement the Provider Incentive Payments Program in Kansas, and
- An HIT road map for Kansas Medicaid.

The development of the Kansas SMHP is divided into several components:

- **Provider survey and environmental scan.** The Provider Survey (which targets individual Medical Providers, hospitals, and other health care organizations) and the Environmental Scan (which targets larger external collaborative health systems and State systems) serve to gather the information needed for the development of the Current HIT Landscape Assessment, identified by CMS as the "As-Is" Environment. The survey and the scan will be utilized both in the Medicaid and the larger statewide effort. An initial round of data gathering has been completed, and KHPA is currently working with its contractor and with providers to improve the process and to solicit additional participation by providers.
- **Development of SMHP through federally-funded contractors.** The SMHP will utilize the data from the Provider Survey and Environmental Scan to depict the HIT "As-is" state in Kansas, and to identify the steps

necessary to implement agency goals. The SMHP will be developed through contract with a vendor using HITECH grant funds.

- **Identifying needed improvements in systems.** In order to efficiently administer and issue the Kansas Medicaid HIT provider incentive payments, the Kansas Medicaid Management Information System (MMIS) will require significant system enhancements. Kansas plans to join an effort led by the Pennsylvania Medicaid Agency and partner with twelve other states to develop the core MMIS enhancements and share the state portion of the costs. Design of these core enhancements is nearing completion. Further changes may be necessary in coming years to collect and use information for Medicaid beneficiaries to improve care coordination and achieve higher stages of meaningful use.

Timeline through June 2011:

The timeline below reflects activities necessary for the SMHP development and the issuance of provider incentive payments. The SMHP will then include a roadmap for further Kansas Medicaid HIT activities.

Task	Projected Completion Date
Provider Survey And Environmental Scan	
Initial Provider Survey Performed	8/27/2010
Preliminary Survey Analysis Completed	9/16/2010
Investigate Potential Extension of Provider Survey	11/5/2010
Environmental Scan Completed	8/10/2010
State Medicaid HIT Plan (SMHP)	
Release RFP for SMHP Plan Vendor	10/26/2010
Award SMHP Vendor Contract	12/21/2010
Submit SMHP to CMS/ONC for approval	3/11/2011*
Provider Incentive Payments	
Test and Install MMIS Enhancements	May 2011
Begin Issuing Provider Incentive Payments	June 2011*

* Kansas HIT provider incentive payments will be issued in calendar year 2011 after CMS approves the SMHP. June 2011 is the current estimate for initial payment distribution.

ATTACHMENT 1

Medicaid Incentive Payments						
	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
CY 2011	$21,250					
CY 2012	$8,500	$21,250				
CY 2013	$8,500	$8,500	$21,250			
CY 2014	$8,500	$8,500	$8,500	$21,250		
CY 2015	$8,500	$8,500	$8,500	$8,500	$21,250	
CY 2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
CY 2017		$8,500	$8,500	$8,500	$8,500	$8,500
CY 2018			$8,500	$8,500	$8,500	$8,500
CY 2019				$8,500	$8,500	$8,500
CY 2020					$8,500	$8,500
CY 2021						$8,500
TOTAL	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

- For calendar years 2011 to 2021, a Medicaid EP may receive up to 85% of the net average allowable costs for certified EHR technology, including support and training up to a maximum level. Incentive payments are available for up to six years.
- Incentive payments are made by the State based on the calendar year.
- An EP may receive a maximum of $21,250 for the first calendar year in which an incentive payment is received, with payments limited to $8,500 for the subsequent 5 years of program participation (*see table below*).
- Acute care hospitals with at least 10% Medicaid patient volume are eligible for incentive payments, as are children's hospitals of any patient volume. Designated State entities that promote the adoption of certified EHR technology are also eligible to receive incentive payments through arrangements with EPs under certain conditions.

SOURCE http://www.docehrtalk.org/funding-incentives/stimulus-funds –the RI Regional Exchange Center

13-6

Medicare Incentive Payments					
	CY 2011	CY 2012	CY 2013	CY2014	CY 2015 and later
CY 2011	$18,000				
CY 2012	$12,000	$18,000			
CY 2013	$8,000	$12,000	$15,000		
CY 2014	$4,000	$8,000	$12,000	$12,000	
CY 2015	$2,000	$4,000	$8,000	$8,000	$0
CY 2016		$2,000	$4,000	$4,000	$0
TOTAL	$44,000	$44,000	$39,000	$24,000	$0

Incentive Payment Amounts

- An EP can receive incentive payments for up to 5 years, with payments beginning as early as 2011. The maximum amount of total payments is $44,000.
- The incentive payment is equal to 75% of Medicare fee-for-service allowable charges for covered services furnished (ie, provided) by an EP in a payment year, subject to a maximum payment.
- For an early EHR adopter whose first payment year is 2011 or 2012, the maximum payment is $18,000 in the first year. Incentive payments decrease if first year is after 2012, with annual payment limits in the first, second, third, fourth and fifth years of $15,000, $12,000, $8,000, $4,000 and $2,000, respectively (*see table below*).
- There will be no payments to an EP who first becomes a meaningful EHR user in 2015 or 2016.
- There will be no payments for meaningful EHR use after 2016.
- Incentive payments are increased by 10% for an EP who predominantly furnishes services in a health professional shortage area.

SOURCE http://www.docehrtalk.org/funding-incentives/stimulus-funds –the RI Regional Exchange Center

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KANSAS HEALTH POLICY AUTHORITY

Joint Committee on Health Policy Oversight
November 5, 2010

Update on Medicaid Pharmacy Policies Adopted by the 2010 Kansas Legislature

- Reduce Coverage of Certain Over-the-counter Medications

  Coverage for prescription drugs is optional for state Medicaid programs, but currently all states cover prescription drugs for at least some Medicaid beneficiaries. Many state Medicaid programs also cover Over-The-Counter (OTC) medications, which can be purchased at drugstores without a prescription, though Medicaid requires that the OTC medication be ordered by a physician or nurse to be paid for by Medicaid. Often, OTC medications fulfill a medical need that cannot be met by a prescription-only product. For example, Children's Tylenol (acetaminophen), a staple for treatment of fever in children, is only available as an OTC medication.

  A survey conducted by the National Pharmaceutical Council (NPC) questioned states about the coverage of eight categories of non-prescription drugs: allergy, asthma, and sinus medications; analgesics; cough and cold medicines; smoking deterrents; digestive products; H2 agonists (drugs to treat ulcers and gastrointestinal reflux); feminine products; and topical products. In 2005, thirty states reported covering at least some OTC drugs in seven or more of the categories. In an effort to limit Medicaid pharmaceutical expenditures states have placed various restrictions on OTC drugs.

  A 2010 Kansas legislative policy to eliminate coverage of certain over the counter medications for Medicaid beneficiaries is estimated to achieve savings of $71,260 SGF. Previous Kansas Medicaid policy related to OTC coverage included the coverage of some agents which ameliorated unpleasant symptoms, but would not necessarily address a critical medical need. Under the 2010 legislative policy, coverage of products not necessary to meet a medical need will not be covered by Kansas Medicaid, even if prescribed by a physician or nurse. Examples include moisturizing eyedrops and nose sprays.

  Current status: Change of coverage of over the counter medications requires submission of a State Plan Amendment (SPA). A SPA has been submitted and is under review by CMS.

- Pursue more aggressive pricing for specialty drugs

  In both private and publically funded health plans, specialty drugs are being recognized as major source of increasing cost of the pharmaceutical component of health care. In January 2010, the Government

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JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT
DATE: 11-5-10
ATTACHMENT: 14

Accountability Office (GAO) released a report on government spending on specialty medications in Medicare, concluding that management of cost in this category is challenging. There is no standard definition of a "specialty drug," and each health plan's list is unique, but in general, a specialty drug includes any drug that is injected or infused, drugs which are very expensive (i.e. more than $5,000 for a month of therapy), or drugs used to treat diseases that require complex care (such as cancer, cystic fibrosis, hemophilia). Medicaid agencies are following the trend already seen in many private health plans, and are creating specific policies and reimbursement mechanisms for specialty drugs.

A 2010 Kansas legislative policy to pursue more aggressive pricing for specialty drugs is estimated to save $94,000 SGF. Currently, specialty drugs are not priced in a different manner than other medications covered by Kansas Medicaid, which is Average Wholesale Price (AWP), minus 13% if the medication is made by only one manufacturer, or AWP minus 27%, if the medication is produced by more than one company. Under the 2010 legislative policy, a more aggressive reduction in the price of the medication would be utilized, such as AWP minus 17% for specialty medications made by one manufacturer. The AWP list is supplied to the Kansas Medicaid fiscal agent by a subcontractor, FirstData Bank. FirstData Bank provides AWP to a majority of other state Medicaid agencies as well. Due to a lawsuit settlement, as of September 2011, FirstData Bank will stop supplying AWP to their customers. This has resulted in the need for Kansas and many other state Medicaid agencies to establish a new pricing base, since the base currently utilized will no longer be available. Potential options for the most appropriate replacement of the current AWP pricing are being analyzed by Medicaid staff. More aggressive pricing for specialty drugs is included in the analysis of other potential options for reimbursement mechanisms. Once determined, significant reprogramming of claims processing system will be required.

Current status: Once Kansas selects a replacement for the AWP a more aggressive pricing strategy for specialty drugs will be developed.

- Limit first fill of a name brand prescription to 15 days

For any patient starting a new medication, there is a possibility that the medication may not work as well as the patient or prescriber was hoping, or that the patient may experience unpleasant side effects (such as stomach upset, or itchy skin) that results in the patient wishing to try a different medication. If enough medication for a month of therapy was dispensed to the patient, inability or unwillingness to continue taking the prescribed medication can result in weeks' worth of medication being unused. Unlike many goods, once dispensed, medications cannot be returned to the pharmacy and therefore that unused medication is wasted. For costly medications, wasting several weeks' worth of medication means that Medicaid paid for hundreds of dollars of medication that goes unused.

Limiting the quantity to be filled the first time a medication is prescribed is a cost-containment tool that is not widely used, but is gaining popularity in private health plans and other state Medicaid programs, including neighboring Missouri Medicaid. A decrease in the first fill quantity allowed by Kansas Medicaid for costly medications from 31 to 15 as outlined in 2010 legislative policy is projected to save $84,000 SGF.

Current status: The policy outlining the new limitation has been written, and is currently in programming design phase.

- Expand Drug Use Reviews, provider education, and peer intervention

  Incorporation of a Drug Utilization Review (DUR) program is federally required for all state Medicaid programs. K.A.R. 39-7, 118 and 39-7, 119 outline the responsibilities and membership of the Kansas Medicaid Drug Utilization Review Board. DUR programs generally involve use of software programs that identify patients whose drug therapy is inappropriate, based on their medical history and medical practice guidelines. Inappropriate therapy may mean too much, or too little, of one or more medications. Once patients are identified, their prescribers are contacted with therapy recommendations, usually via letter and occasionally with a follow-up phone call or in-person visit. The Kansas Medicaid DUR Board selects five topics or diseases (i.e. diabetes, high blood pressure) every year; Medicaid claim information is then used to identify patients who may be on inappropriate therapy for that disease and letters are mailed. The Kansas DUR program also includes sixty in-person visits by the DUR pharmacist to prescriber's offices to help educate them on best practices and Medicaid policy.

  In addition to the federally mandated program, Kansas utilized from 2006-2009 a drug utilization review program that focused on mental health drugs. The contractor supplying this program was Comprehensive Neurosciences (CNS), and was funded by a grant from the drug manufacturer Eli Lilly. Expanded use of this program was projected in 2010 legislative policy to provide a cost-savings of $175,000 SGF. Expanded use was to include mailing letters to a larger sample of prescribers, using a larger quantity of best practice indicators, and to incorporate more aggressive direct peer-to-peer contact.

  Current status: KHPA developed a request for an expanded program based upon the advice of the Mental Health Prescription Drug Advisory Committee. However, Eli Lilly has opted to discontinue funding the CNS program. The agency is seeking other sponsors as the agency believes prescribing issues are still present and need to be addressed.

- Implement 4 brand name prescription per month limit and tiered formulary

  Many state Medicaid programs utilize monthly prescription limits, both on overall number of prescriptions and on number of brand prescriptions, as a cost-control mechanism on pharmaceutical expenditures. Some states cover as few as two brand name prescriptions and six prescriptions overall. Under current Kansas Medicaid policy, beneficiaries can receive five brand-name medications in a calendar month; for the sixth medication, policy requires the pharmacy to document the "medical necessity" of receiving more than five brand name medications. Implementation of 2010 legislative policy will change the allowed number of brand name medications without documentation of necessity from five to four. Certain classes of medications are exempted from the brand limitation; those exemptions will be reviewed at an upcoming DUR Board meeting. 2010 legislative policy exempted all mental health drugs from inclusion in the new brand limitation.

  Utilization of a tiered formulary is common among private health plans, and is also used by some state Medicaid programs. Tiered formularies designate some medications as preferred over others, and require that patients pay different co-payment or co-insurance amounts for each tier of the formulary. For states using tiered formularies, co-payments for each tier range from zero to three dollars, as allowed by federal law. Currently for Kansas Medicaid all prescriptions eligible for co-pays (several population groups are excluded by federal regulation) have a $3 co-pay. Many other state Medicaid programs also have a flat $3 co-pay.

Current status: Changing the monthly prescription limit requires change in the Medicaid State Plan. A SPA has been submitted and is under review.

- Enhanced PA system

Given continued cost increases, the healthcare system must replace inefficient manual processes with technology-based solutions wherever possible. Prior authorizations are a case-in-point.
For modern healthcare companies, a typical way of controlling costs is to focus on certain risky or high priced medicines and services ordered by healthcare providers. The most common method to manage these costs is to require authorization or pre-certification from the health plan before dispensing expensive medical procedures, drugs and/or treatment services to the plan participant. This is performed by:

- Gathering the information needed to make an authorization or precertification decision
- Applying appropriate decisioning criteria to the request
- Communicating the decision clearly and quickly to the healthcare provider and the plan participant
- Updating internal records in adjudication/claims systems and call tracking systems

The primary purpose of prior authorization (PA) is to ensure medical services and prescription drugs provided to beneficiaries are medically necessary and cost effective. PA programs manage a significant portion of Medicaid costs by requiring prescribers to obtain approval before certain medications are dispensed or medical services are provided. This is accomplished by identifying, researching and reviewing treatment plans and/or requested services or medication before the service is provided or the medication is dispensed. Additional information used to make these prior authorization determinations are the beneficiary's eligibility, the place and type of service requested, as well as the diagnosis. More specific medical details are required for some services.
The purpose of enhancing the PA process is to migrate from the mostly manual current process to a more automated process with the objective of minimizing the overall time required for all parties involved in obtaining prescriptions or medical services, and reducing administrative costs for payers and providers.
Savings anticipated from implementation of is enhanced prior authorization is estimated at $1.5 million (AF) in State Fiscal Year 2011.

Current status: An Enhanced Prior Authorization RFP was released in July, bids have been submitted and evaluated. Award of the contract is pending CMS approval. The contract was sent to CMS in October. The anticipated timeline from contract award to implementation is 4-5 months.

Update on the verification of prescription drugs to avoid abuse project

The non-medical use or abuse of prescription drugs is a serious and growing public health problem both in Kansas and across the country. According to the 2007 National Survey on Drug Use and Health, approximately 4.8% (109,000) of Kansans 12 years of age and older used a prescription pain reliever for non-medical purposes within the past 30 days. In that same year, 5.2 million Americans 12 years of age and older—2.1% of the population—used a prescription pain reliever for non-medical purposes in the past month. Since 2004, the non-medical use of prescription pain relievers has increased by 0.6% among Kansans and by 0.3% among all Americans.

Addressing the increase of prescription drug abuse is a focus nationwide. Thirty-four states have a Prescription Monitoring Program (PMP) currently active, and programs in nearly a dozen more states, including Kansas, will

be active soon. PMPs allow prescribers and pharmacists to review a patient's full medication history prior to prescribing or filling a narcotic, rather than having only the patient's history with that individual practitioner to review. Use of PMPs decreases a potential abuser's ability to get multiple prescriptions from multiple prescribers and pharmacies for personal use or sale. The Kansas PMP is poised to become active within the next few months. It is operated by the Kansas Board of Pharmacy.
Kansas Medicaid has, for many years, had limitations on a number of substances that have abuse potential. Incorporation of additional restrictions were proposed and approved by the Medicaid DUR Board in early 2010 and were endorsed by legislative policy direction in 2010. Additional restrictions include: dose optimization of long-acting narcotics, prevention of use of more than one long-acting narcotic simultaneously without prior authorization, and prevention of use of short-acting narcotics in any combination above what has been recommended by the American Pain Society as a high dose without prior authorization. For those patients for whom a higher dose of narcotics may be necessary to adequately manage their pain, the prescriber is required to have the patient sign a "pain contract."

The Patient Protection and Affordable Care act includes a provision that all prescribers must be enrolled in Medicaid. This provision's effective date is January 1, 2011. Under current Medicaid policy, the medication prescriber does not have to be enrolled Kansas Medicaid. Implementation of this provision will provide additional controls on prescribing of controlled substances.

Current status: Dose optimization of long-acting narcotics was fully implemented on 11/02/2010. Policies regarding short-acting and long-acting narcotics have been written and are in the system design phase.

KANSAS

DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

Don Jordan, Secretary

Joint Committee on Health Policy Oversight
November 5, 2010

Food Assistance Overview

Deputy Secretary Laura Howard

For Additional Information Contact:
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KANSAS
DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

Food Assistance Overview

Joint Committee on Health Policy Oversight
November 5, 2010

Chairwoman Landwehr and members of the committee, thank you for the opportunity to brief you on the Food Assistance Program. My name is Laura Howard, Deputy Secretary for the Department of Social and Rehabilitation Services. The Food Assistance program is a federal program administered by SRS which provides a monthly benefit to eligible low-income households to assist them in purchasing food for home consumption. The program is administered at the federal level by the United States Department of Agriculture (USDA). At the federal level, the Food Stamp Program was changed to State Nutrition Assistance Program or SNAP. In Kansas, we call this program the Food Assistance Program.

Eligibility for the Food Assistance Program is based on financial and non-financial factors. With certain exceptions, a household that meets the eligibility requirements is qualified to receive benefits. Generally, households with income below 130% of federal poverty and with no more than $2000 in countable assets can qualify for the program. Households with at least one member who is 60 or older can have up to $3000 in assets. A household is defined as a single individual or group of individuals who live and eat together.

In Kansas, the program currently serves 277,579 persons, of which 46% are children. This is a 20% increase over in the total number of persons served from FY 2009. The average monthly benefit per person is $126.66, and the average benefit per household is $277.35. In FY 2010, Kansas issued a total of $383,275,641, compared to $263,141,527 in SFY 2009. These benefits are spent at local grocery stores, farmers' markets and other stores in Kansas to purchase food for home consumption. Only food and plants/seeds to grow food can be purchased with food assistance benefits.

There are many benefits to increasing participation in the Food Assistance Program including helping more low income families with their food and nutrition needs as well as transition to self sufficiency. In addition, the increased food buying power generated by the program generates economic activity, supports the local and state economy, and supports farming in Kansas. Every $5 in food assistance generates $9.20 in economic activity.

The Food Assistance Program supports nutrition education, which is designed to help food assistance participants choose healthy foods and active lifestyles. The State of Kansas contracts with Kansas State

University Extension Service to provide nutrition education. In Kansas, the nutrition education program (SNAP-Ed) is known as the Family Nutrition Program.

The objectives of the Family Nutrition Program (FNP) are:

- Improve dietary quality by providing information on dietary guidelines and My Pyramid
- Increase fruit and vegetable consumption - a fruit and vegetable newsletter is mailed with each food assistance review
- Increase food resource management skills - "food shopping on a budget"
- Increase participation in physical activity

Food Assistance benefits are issued electronically on the Vision card. The Kansas Vision card – an electronic benefits transfer (EBT) card – acts similarly to a debit card in that it can be used at a point-of-service machine or ATM to pull funds out of an account, if there are funds in the account. The Vision card cannot be used to pull funds from a person's personal bank account – only benefits from an EBT account. The federal Food and Nutrition Service (FNS) enrolls grocery stores for program participation, and cardholders can access SNAP benefits to purchase food at authorized retailers. By using bar code technology, scanners are able to determine food vs. non-food items. Only eligible food items can be purchased with SNAP benefits. FNS mandates SNAP benefits to be on EBT but states do utilize the technology for other programs as well. Current programs on EBT include Food Assistance, all cash programs and child care. Each program's benefits are on the card in separate accounts with separate spending rules.

Food items eligible for SNAP are determined by FNS. Households can use SNAP benefits to buy foods for the household to eat, such as breads and cereals; fruits and vegetables; meats, fish and poultry; and dairy products. Seeds and plants which produce food for the household to eat may also be purchased. Households cannot use SNAP benefits to buy beer, wine, liquor, cigarettes or tobacco; non food items such as pet foods, soaps, paper products and household supplies; vitamins and medicines; foods that are to be eaten in the store; or hot foods.

FNS also establishes the standards for stores to meet to be eligible to accept SNAP benefits. Stores who desire to accept SNAP benefits must sell food for home preparation and consumption and meet at least one of the following two criteria. 1) The store must offer for sale at least three different varieties of food in each of the following four staple food groups, with perishable foods in at least two categories, on a daily basis. These items include: bread and grain, dairy, fruits and vegetables, and meat, poultry or fish. 2) The store must have at least 50 percent of their total sales (e.g., food, non-food, services, etc.) be from the sale of eligible staple foods. Staple foods are defined as a basic dietary item (e.g., bread, flour, fruits, vegetables, beef, chicken, fish, etc.). Snack or accessory foods; such as chips, soda, coffee, condiments, and spices, are not staple foods. In addition, ready to eat, prepared foods cannot be counted as staple foods.

In 2010, 14 Farmers' Markets in Kansas had the ability to accept the Vision card for fresh, local, fruit and vegetable purchases. Funding to support the start up costs of each market was provided by USDA High Performance Bonus Money awarded for improved food assistance error rates in FFY 2008. Organizations

continue to expand this capacity with federal or other grants and funding sources. The Kansas Rural Center was recently approved for a USDA Specialty Crop Block Grant to add at least 6 new markets to the program in 2011. Attached is a current listing of Farmer's Markets that accept EBT.

SNAP program integrity is maintained through Quality Control activities performed by both state and federal agency staff. Food and Nutrition Services (FNS) has the primary responsibility for monitoring any fraudulent activity by retailers and the individual states for recipients. While traditional methods of fraud, (identified under the coupon distribution/redemption system) are reduced through the use of Electronic Benefit Transfer (EBT), the nature of electronic transactions also introduces previously unknown approaches to committing fraud. Methods of detecting (and ultimately preventing) food stamp fraud by EBT-enabled retailers are essential to the successful management of the benefit redemption process.

The ALERT system receives daily transaction records from EBT processors and conducts analysis of patterns in the data, which indicate potential fraudulent activity by stores. FNS investigators and compliance offices use these reports to support case management. Other users include USDA Office of the Inspector General (OIG) investigators and the staff members of regional and field offices. ALERT system managers and developers continually review data and develop new detection patterns for their use.

The Food Stamp Act mandates that each state operate a Quality Control (QC) System to monitor and improve the administration of Supplemental Nutrition Assistance Program (SNAP). The state is required to review a randomly selected statewide sample of active (open) SNAP cases and negative cases (those that have been denied, closed, or suspended). A subset of each monthly sample is re-reviewed by USDA to assure the state's QC reviewers are following federal guidelines. The purpose of the QC reviews is to determine the state's payment error rate and liability for payment errors, eligibility for enhanced funding, and adherence to timeliness standards in application processing. Kansas QC annually reviews approximately 1200 open SNAP cases and 800 negative cases for errors.

Other SNAP Fraud Initiatives within the state include the review and analysis of the following EBT reports: EBT Report of Excess Vision Card Replacements, EBT Report of Benefits Spent Out of State, and EBT Report of Excessive Large Dollar Purchases. Cases identified within these reports result in further inquiry and investigation as warranted. A Single State Audit is performed every three years on the SNAP program. These best practices provide for early detection and prevention of fraud and follow up on allegations of fraud determined to be verified.

Overall, the Food Assistance Program is an effective and critical support for low income Kansans. I will be happy to stand for questions.

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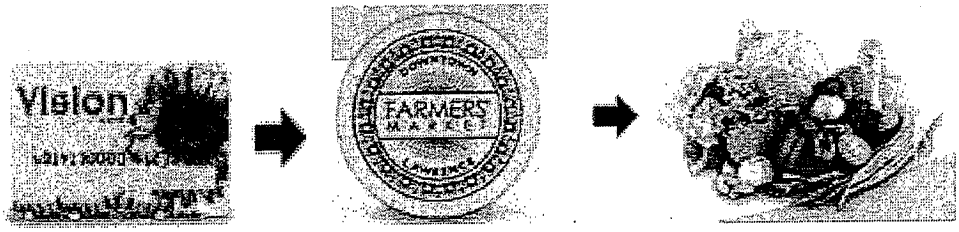
14 Kansas Farmers Markets

are now accepting Vision cards!



How can I use my Vision card?

- Go to the market information booth.
- Swipe your Vision card for market tokens like the one above.
- Exchange your tokens for approved items throughout the market.

Eligible Items –

Fruits, vegetables or herbs; fish or poultry; baked goods; dairy, honey; processed foods like pickles, jam or salad dressings; cider or non-alcoholic beverages; and seeds or plants for a home garden.

Kansas Farmers' Markets –

Allen
Allen County Farmers Market, Iola
Thursday, 5:30 PM – 7:30 PM

Anderson
Garnett Farmers Market
Thursday, 4:30 PM – 7:00 PM

Atchison
Atchison Farmers Market
Saturday, 8:00 AM – 12:00 PM
Wednesday, 2:30 PM – 5:30 PM

Butler
Central Park Farmers Market, Andover
Wednesday, 3:30 PM – 6:30 PM

Crawford
Pittsburg Farmers Market
Saturday, 7:30 AM – Sell Out
Wednesday, 12:00 PM – Sell Out

Douglas
Lawrence Farmers Market
Saturday, 7:00 AM – 11:00 AM
Tuesday, 4:00 PM – 6:00 PM
Thursday, 4:00 PM – 6:00 PM
(3 locations)

Leavenworth
Leavenworth Farmers Market
Saturday, 7:00 AM – 11:00 AM
Wednesday, 3:00 PM – 6:00 PM

Lyon
Emporia Farmers Market
Saturday, 8:00 AM – Sell Out
Wednesday, 5:00 PM – Sell Out

Marion
Hillsboro Farmers Market
Thursday, 5:00 PM – 7:00 PM

Reno
Reno County Farmers Market, Hutchinson
Saturday, 7:30 AM – 12:30 PM
Wednesday, 11:30 AM – 4:30 PM
Thursday, 4:30 PM – Sell Out
(2 locations)

Sedgwick
Kansas Grown Farmers Market
Saturday, 7:00 AM – 12:00 PM
Wednesday, 3:00 PM – 7:00 PM

Old Town Farmers Market
Saturday, 7:00 AM – 12:00 PM

Wyandotte
KCK Green Market
Saturday, 10:00 AM – Sell Out
Wednesday, 8:00 AM – Sell Out

Rosedale Farmers Market
Sunday, 12:00 PM – 4:00 PM

Check out the website with up to date information of Kansas Farmers' Markets:
http://www.ksfarmersmarkets.org/news/using-your-vision-card-at-the-farmers-market

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For more information about the Kansas Farmers Market EBT Expansion Project contact: Mercedes Taylor-Puckett, Project Coordinator (785) 840-6202, info@ksfarmersmarkets.org

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November 2, 2010

To: Legislative Budget Committee and Governor Mark Parkinson

From: Kansas Legislative Research Department and Kansas Division of the Budget

Re: Human Services Consensus Caseload Estimates for FY 2011 and FY 2012

The Division of the Budget, Department of Social and Rehabilitation Services, Kansas Health Policy Authority, Department on Aging, Juvenile Justice Authority, and the Legislative Research Department met on October 28, 2010 to revise the estimates on human services caseload expenditures for FY 2011 and to make initial estimates for FY 2012. The caseload estimates include expenditures for Nursing Facilities, Regular Medical Assistance, Temporary Assistance to Families, General Assistance, the Reintegration/Foster Care Contracts, psychiatric residential treatment facilities, and out of home placements. A chart summarizing the estimates for FY 2011 and FY 2012 is included at the end of this memorandum. The estimate for FY 2011 is increased by $49.3 million from the State General Fund and $98.0 million from all funding sources. The new estimate for FY 2012 then increases by $248.8 million from the State General Fund and $78.7 million from all funding sources. **The combined increase for FY 2011 and FY 2012 is an all funds increase of $176.7 million and a State General Fund increase of $298.1 million.**

The estimates include Medical Assistance expenditures by both the Kansas Health Policy Authority (KHPA) and the Department of Social and Rehabilitation Services (SRS). Most health care services for persons who qualify for Medicaid, MediKan, and other state health insurance programs were transferred to the KHPA on July 1, 2006, as directed in 2005 Senate Bill 272. Certain mental health services, addiction treatment services, and services for persons with disabilities that are a part of the Regular Medical Assistance Program remain in the budget of SRS.

FY 2011

For FY 2011, the estimate is an all funds increase of $98.0 million and a State General Fund increase of $49.3 million as compared to the budget approved by the 2010 Legislature. The amount approved for Medicaid programs by the 2010 Legislature assumed the full extension of the American Recovery and Reinvestment Act (ARRA) for all of FY 2011. The original Act authorized enhanced federal match until December 2010. The actual extension passed by Congress reduces the across-the-board federal match increase from 6.2 percentage points under the original act to 3.2 percentage points from January 1, 2011-March 31, 2011, and 1.2 percentage points from April 1, 2011-June 30, 2011. The portion of the State General Fund increase in FY 2011 totaling $43.0 million is attributable to the lower than originally anticipated funding from the American Recovery and Reinvestment Act (ARRA) funding. The decrease in anticipated federal match rate also impacts Medicaid programs not included in the caseload process. The total amount of reduced federal funds due to the reduced ARRA funding totals $53.9 million.

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The remaining State General Fund increase totaling $6.3 million is attributable to caseload growth above the approved amount for FY 2011. The all funds increase is due largely to increased estimates for Mental Health expenditures, regular medical expenditures and nursing facilities expenditures, partially offset by a decrease in out of home placements and Psychiatric Residential Treatment Facilities. The SRS Mental Health increase of $13.4 million in all funds and $5.8 million State General Fund increase in FY 2011 reflects an increase in beneficiaries and an increase in the payment rates for both the Prepaid Ambulatory Health Plan (PAHP) and the Psychiatric Residential Treatment Facilities. Expenditures for the regular medical program have increased by $8.4 million from all funding sources, including $30.5 million from the State General Fund. Estimates of Nursing Facilities expenditures increased by $72.0 million, including $10.1 million from the State General Fund, attributable to increased estimated cost per person and the addition of $64.1 million from all funding sources to account for funds generated by the nursing facility provider assessment.

FY 2012

The FY 2012 initial estimate is $2.4 billion, including $1.0 billion from the State General Fund. The estimate is an all funds increase of $78.7 million and a State General Fund increase of $248.8 million as compared to the revised FY 2011 estimate. The portion of expenditures anticipated to be funded by the federal government for the Medicaid program have decreased due to the end of the American Recovery and Reinvestment Act (ARRA) funding at the end of June 2011. The increased amount of State General Fund required for matching in FY 2012 for caseload expenditures is estimated to be $175.6 million. The total amount of funding needed to replace federal funds for caseload and non-caseload programs as a result of the elimination of ARRA enhanced Medicaid funding totals $216.0 million in FY 2012. The base Medicaid matching rate for federal contribution, excluding ARRA funding, was reduced by 1.6 percent between FY 2011 and FY 2012. The estimated impact of this reduction in FY 2012 is $35.3 million for caseload expenditures. The impact of the base federal match rate on non-caseload items is estimated to be increased State General Fund expenditures of $9.1 million in FY 2012. The remaining increases reflect caseload growth, for both increased individuals and cost increases, totaling $94.9 million from all funding sources and $37.9 million from the State General Fund in FY 2012.

Regular Medical expenses for KHPA were increased by $168.3 million from the State General Fund and $65.4 million from all funds due to estimated increases in caseloads and higher per person expenditures. This estimate includes a decrease in fee fund expenditures for the state match and a corresponding increase of State General Fund expenditures attributable to decreased fee fund revenue projections for the Kansas Health Policy Authority for FY 2012. The fee fund revenue projection does include an assumption of continued revenue from the health care cost containment contract in FY 2012 at a lower amount than FY 2011.

Nursing Facility expenditures were decreased by $7.8 million all funds, but increased by $43.0 million from the State General Fund, due to increased cost per person, partially offset by a decreased estimate for the second year of the provider assessment expenditures. Caseloads for Temporary Assistance for Families have increased by $3.0 million, from all funding sources, due to increased estimates regarding the numbers of persons accessing services. The SRS Mental Health increase of $9.7 million in all funds and the $28.0 million State General Fund increase in FY 2012 generally is tied to estimated increases in beneficiaries and cost per person for the Prepaid Ambulatory Health Plan (PAHP). In addition, the estimate for the foster care contract is estimated to increase by $5.5 million from all funding sources, due to an estimated increase in the number of children receiving services and an increased cost per child.

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Human Services
November 2, 2010
Consensus Caseloads Estimates

Program		FY 2011 Approved	November Revised FY 2011	Difference from Approved	November Estimate FY 2012	Diff. From FY 2011 Estimate
Nursing Facilities	SGF	$ 112,857,112	$ 123,000,000	$ 10,142,888	$ 166,000,000	$ 43,000,000
	AF	373,700,000	445,706,642	72,006,642	437,900,247	(7,806,395)
Targeted Case Management (Aging)	SGF	$ 1,532,869	$ 1,634,935	$ 102,066	$ 2,200,000	$ 565,065
	AF	5,092,093	5,072,712	(19,381)	5,169,173	96,461
Psychiatric Residential Treatment Facilities (PRTFs) (JJA)	SGF	$ 2,439,439	$ 2,151,953	$ (287,486)	$ 2,979,200	$ 827,247
	AF	7,816,022	6,676,862	(1,139,160)	7,000,000	323,138
Out of Home Placements (JJA)	SGF	$ 20,892,477	$ 17,843,651	$ (3,048,826)	$ 19,000,000	$ 1,156,349
	AF	23,718,873	21,622,100	(2,096,773)	22,000,000	377,900
Nursing Facilities for Mental Health (NFMH)	SGF	$ 14,000,000	$ 14,000,000	$ 0	$ 14,500,000	$ 500,000
	AF	16,258,274	18,562,101	2,303,827	18,742,269	180,168
Temporary Assistance for Families	SGF	$ 29,821,028	$ 29,821,028	$ 0	$ 29,821,028	$ 0
	AF	54,039,150	54,500,000	460,850	57,500,000	3,000,000
General Assistance	SGF	$ 3,024,000	$ 3,024,000	$ 0	$ 3,200,000	$ 176,000
	AF	3,024,000	3,024,000	0	3,200,000	176,000
Reintegration/ Foster Care	SGF	$ 86,586,575	$ 91,000,000	$ 4,413,425	$ 91,000,000	$ 0
	AF	136,165,704	139,000,000	2,834,296	144,450,000	5,450,000
Regular Medical (KHPA)	SGF	$ 351,204,882	$ 381,731,500	$ 30,526,618	$ 550,000,000	$ 168,268,500
	AF	1,336,228,635	1,344,600,000	8,371,365	1,410,000,000	65,400,000
Mental Health (SRS)	SGF	$ 74,181,170	$ 80,000,000	$ 5,818,830	$ 108,000,000	$ 28,000,000
	AF	241,920,135	255,300,000	13,379,865	265,000,000	9,700,000
Community Supports and Services (SRS)	SGF	$ 9,955,014	$ 10,979,652	$ 1,024,638	$ 14,600,000	$ 3,620,348
	AF	32,837,496	34,066,560	1,229,064	34,304,511	237,951
AAPS/PIHP* (SRS)	SGF	$ 5,729,724	$ 6,300,000	$ 570,276	$ 9,000,000	$ 2,700,000
	AF	18,900,000	19,547,006	647,006	21,146,617	1,599,611
TOTAL	**SGF**	**$ 712,224,290**	**$ 761,486,719**	**$ 49,262,429**	**$ 1,010,300,228**	**$ 248,813,509**
	AF	**2,249,700,382**	**2,347,677,983**	**97,977,601**	**2,426,412,817**	**78,734,834**

SGF – State General Fund
AF – All Funds
*Addiction and Prevention Services (AAPS)/Prepaid Inpatient Health Plan (PIHP)

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KANSAS

DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

Don Jordan, Secretary

Joint Committee on Health Policy Oversight

November 5, 2010

Home and Community Based Services Waivers

&

Potential Impact of Federal Health Care Reform

Deputy Secretary Ray Dalton

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KANSAS
DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

Home and Community Based Services Waivers
&
Potential Impact of Federal Health Care Reform

Joint Committee on Health Policy Oversight

November 5, 2010

Chairwoman Landwehr and members of the Committee, thank you for the opportunity to appear before you today. I am Ray Dalton, Deputy Secretary of Disability & Behavioral Health Services at the Kansas Department of Social and Rehabilitation Services. Today I will present information regarding six Home and Community Based Service Waivers that provide services to persons with disabilities, including the number of individuals served and funding for each of the programs. I have included a chart with more detail on the waivers in Attachment A. In addition, I will briefly address the potential impact of the federal Patient Protection and Affordable Care Act as it relates to the Medicaid services managed by SRS.

Background

Medicaid waivers are federally approved requests to waive certain specified Medicaid rules. For instance, federal Medicaid rules generally allow states to draw down federal Medicaid funds for services provided in institutions for persons with severe disabilities. Many of the community supports and services provided to persons with disabilities such as respite care, attendant care services, and assistive services, are not covered by the regular federal Medicaid program. HCBS waivers give the state federal approval to draw down federal Medicaid matching funds for community supports and services provided to persons who are eligible for institutional placement, but who choose to receive services that allow them to continue to live in the community. The Centers for Medicare and Medicaid Services (CMS) requires that the cost of services paid through HCBS waivers be, on the average, less than or equal to the cost of serving people in comparable institutions.

Developmental Disability (DD) Waiver

The DD waiver serves individuals with significant developmental disabilities. As of October 1, 2010, there are 2,334 people on the waiting list receiving no waiver services, and another 989 people receiving some services who are waiting for additional services. In FY 2010 there were 295 individuals who left waiver services. These

positions were filled by individuals in crisis situations. SRS maintains one statewide waiting list for HCBS-DD services which includes both the unserved and the underserved. A person's position on the waiting list is determined by the request date for the service(s) for which the person is waiting. Each fiscal year, if funding is made available, people on the statewide waiting list are served, beginning with the oldest request dates at the top of the list. An additional $3.3 million SGF was allocated to the DD waiver for FY 2011. SRS is in the process of working with the Community Developmental Disability Organizations to offer services to individuals on the waiting list. It was originally estimated that at least 145 individuals will be served with this funding. Because the average cost of the people on the top of the waiting list had a lower cost per person than the people currently on the waiting list, 214 people have been offered and accepted services.

During FY 2010, $311,275,693 was paid through the DD waiver to serve an average of 7669 people a month.

On January 1, 2010 and on February 1, 2010, there were waiver changes implemented by SRS to assist in avoiding further overspending. The waiver changes included:

- On January 1, 2010, Oral Health Services were eliminated.
- On February 1, 2010, Temporary Respite Care services were eliminated.

Physical Disability (PD) Waiver

During FY 2008 the rate of growth in the waiver increased significantly and on December 1, 2008, SRS implemented a waiting list for the PD waiver. The waiting list was implemented not to cut the budget, but to avoid further overspending. With the implementation of a waiting list approximately 7,300 individuals have been able to continue receiving services. In December 2008 when the waiting list was implemented only persons in a crisis situation were allowed to access new waiver services. On March 2, 2009, the "rolling" waiting list methodology was implemented whereby one consumer was offered services for every two terminations. On January 1, 2010, due to the budget situation, the rolling waiting list methodology was terminated and only persons meeting the crisis criteria were allowed to access PD waiver services (the only other opportunity to access these services was through the MFP grant). As of October 1, 2010, there were 2,503 individuals on the PD Waiver waiting list.

The PD waiver received an additional $3.6 million SGF, which we anticipated would allow for the start of a rolling waiting list in October 2010. However, because the expenditure data for the first three months of FY2011 show a decrease in the number of people served but an increase in the average cost per person we have not instituted the rolling waiting list at this time. We are looking deeper into the data and will continue to monitor the expenditures before instituting the rolling waiting list.

During FY 2010, $140,511,242 was paid through the PD waiver to serve an average of 6,964 people per month.

On January 1, 2010, there were waiver changes implemented by SRS to assist in avoiding further overspending. The waiver changes included:

- Eliminating Oral Health Services.
- Limiting personal services to 10 hours per day unless there is the determination of a crisis situation.

- Limiting assistive services to crisis situations only, with approval by the program manager.
- A change in the crisis criteria was made to eliminate the criteria that a person could enter services if the individual was at significant, imminent risk of serious harm because the primary caregiver(s) were no longer able to provide the level of support necessary to meet the consumer's basic needs due to the primary caregiver(s): own disabilities, return to full time employment, hospitalization or placement in an institution, moving out of the area in which the consumer lived, or death.

Traumatic Brain Injury (TBI) Waiver

The TBI waiver is designed to serve individuals who would otherwise require institutionalization in a Head Injury Rehabilitation Hospital. The TBI waiver services are provided at a significant cost savings over institutional care and provide an opportunity for each person to live and work in their home communities. Each of these individuals is provided an opportunity to rebuild their lives through the provision of a combination of supports, therapies and services designed to build independence.

A significant difference in this program is that it is not considered a long term care program. It is considered a rehabilitation program and consumers are expected to transition off the program or to another program upon completion of rehabilitation. Individuals currently receive up to four years of therapy and, if by that time progress in rehabilitation is not seen, the individual is transitioned to another program. In FY 2010 the average length of stay in this program was 1.9 years. This number is based on the consumers who transitioned from services during FY 2010. There is currently no waiting list for this program.

During FY 2010, $13,085,895 was paid through the TBI waiver to serve an average of 323 people per month.

On January 1, 2010, there were waiver changes implemented by SRS to assist in avoiding further overspending. The waiver changes included:

- Elimination of Oral Health Services.
- Limiting personal services to 10 hours per day unless there is the determination of a crisis situation.
- Limiting assistive services to crisis situations only, with approval by the program manager.
- Moving third year continuation of service review to program manager as opposed to committee.

Technology Assisted (TA) Waiver

The TA waiver is designed to serve children ages 0 to 22 years who are medically fragile and technology dependent, requiring intense medical care comparable to the level of care provided in a hospital setting, for example, skilled nursing services. The services provided through this waiver are designed to ensure that the child's medical needs are addressed effectively in the child's family home, thereby eliminating the need for long term and or frequent hospitalization for acute care reasons. There is no waiting list for this program. The TA waiver served 483 (unduplicated) children in FY2010 at a total cost of $ 24,594,116 and an average monthly cost per person of $ 5,418.

Serious Emotional Disturbance (SED) Waiver

The HCBS waiver for youth with a Serious Emotional Disturbance allows federal Medicaid funding for community based mental health services for youth who have an SED and who are at risk of being placed in a state mental health hospital. The SED waiver determines the youth's Medicaid eligibility based on his/her own income separate from that of the family. Once the youth becomes a Medicaid beneficiary he/she may receive the full range of all Medicaid covered services including the full range of community mental health services. In addition, the youth is eligible for specific services only available to youth on the SED Waiver. The services offered through the SED waiver and other community mental health services and supports are critical in assisting the youth to remain successfully in his/her family home and community. During FY 2010, $48,448,927 was paid through the SED waiver to serve a total of 6,021 children.

Autism Waiver

The autism waiver is the newest of our HCBS waivers with the first funding approved for FY 2008. The target population for the autism waiver is children with autism spectrum disorders (ASD), including autism, Aspergers' Syndrome, and other pervasive developmental disorders. The diagnosis must be made by a licensed medical doctor or PhD psychologist using an approved autism specific screening tool. Children are able to enter the program from the age of diagnosis through the age of five. Children receiving services through this waiver would be eligible for placement in a state mental health hospital if services were not provided through the waiver. A child will be eligible to receive waiver services for a time period of three years with an exception process in place to allow children who demonstrate continued improvement to continue services beyond the three year limit.

The autism waiver was implemented on January 1, 2008. At that time 25 children were selected through a random process to receive services. The other applicants were placed on the waiting list. The 2008 Legislature approved funding for an additional 20 children to be served by the autism waiver in FY 2009. The waiver is now serving 45 children. There are 251 children waiting for services through this waiver. Since this waiver was implemented, 166 children have aged off of the waiting list before services could begin. The total expenditure for the waiver in FY2010 was $743,673 with the average monthly cost per person being $1,546.

SRS Fee Fund

Over the past several years SRS fee fund balances have been used to fill the gap between available SGF and waiver spending and the funds allocated for the HCBS Waivers. The fee fund balance has now been depleted and SRS will be $11 million short for FY 2012. SRS will be requesting an enhancement to replace the $11 million shortfall with the next budget submission. SRS's options regarding changes that may be made to fill this gap are limited by federal regulations that have been implemented through the Recovery Act and the Affordable Care Act. These regulations do not allow states to change the waiver eligibility requirements without loss of federal funding. Under the Recovery Act the number of persons served by the waivers may not drop below the number of individuals that were being served on July 1, 2008. The only options that are

available to SRS to control spending are through serious rate reductions and then to evaluate what additional service limitations could be implemented.

Potential Impact of Federal Health Care Reform

Much of the detail regarding requirements for states in implementing the Patient Protection and Affordable Care Act is yet unknown, because regulations have not yet been issued. From what is known so far, we think Kansas is positioned to implement the various provisions the Act. The various state agencies (Kansas Insurance Department, Kansas Health Policy Authority, SRS, KDHE, KDOA) that would be involved with implementation are all assessing the provisions of the Act, are prepared to review regulations as they are issued, and are actively reviewing and applying for grant opportunities under the act as they become available.

Secretary Jordan has established an internal health reform steering committee to ensure we are evaluating the Act and its potential impact on existing SRS programs and processes. SRS is actively tracking federal regulations and regularly reviewing health care reform funding and grant opportunities reported through Federal Funds Information for States (FFIS). Each division of SRS is reviewing and following the Act's provisions as they become applicable, and is reviewing information, reviews and commentary about the Act and its implementation options developed by various program-area experts.

The most significant immediate impact of the Act relates to maintenance of effort requirements associated with HCBS waiver programs in Kansas. Under the Act, the requirement is that states maintain eligibility standards, methodologies and procedures that were in place as of March 23, 2010. This requirement for adults will expire when the state exchange system is operational, except that for populations with income below 133% of poverty, the requirement expires on January 1, 2014 (when all non-elderly non-disabled adults with incomes up to 133% of poverty will become mandatory eligibles). For children, the maintenance of effort requirement is retained until the end of 2019. Unlike the ARRA, which made compliance with its maintenance of effort provision a condition to receiving ***enhanced*** FMAP, compliance with the maintenance of effort provision in the Act is a condition to receiving ***any*** federal financial participation for the program out of compliance, during the period in which the requirement applies.

Additional potential impact, especially in substantial areas related to covered services, will not be known until benefit packages are established. Changes in benefit packages may have a significant impact on Kansas' mental health and substance abuse treatment service programs, which have been designed around the idea of a large number of uninsured individuals needing access to comprehensive behavioral health services. Additional impact on the HCBS waiver programs in Kansas continues to be evaluated, and will depend in part upon how some of the new waiver options under the Act are operationalized. And finally, through our review of the Act thus far, from an SRS perspective, there does not appear to be a need for any statutory changes in conjunction with the various provisions of the Act.

This concludes my testimony; I will stand for questions.

KANSAS
DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

17-7

Attachment A - Overview of Medicaid Home & Community Based Services Waivers Operated by DBHS/CSS

WAIVER	AUTISM	DEVELOPMENTAL DISABILITY	PHYSICAL DISABILITY	TECHNOLOGY ASSISTED	TRAUMATIC BRAIN INJURY	SERIOUSLY EMOTIONALLY DISTURBED (SED)
Institutional Equivalent	State Mental Health Hospital Services	Intermediate Care Facility for Persons with Mental Retardation	Nursing Facility	Acute Care Hospital	Head Injury Rehabilitation Facility	State Mental Health Hospital
Eligibility	➢ Time of diagnosis through 5 years of age ➢ Diagnosis of an Autism Spectrum Disorder or PDD-NOS ➢ Meet functional eligibility ➢ Eligible for State Institutional	➢ Individuals age 5 and up ➢ Meet definition of mental retardation or developmental disability ➢ Eligible for ICF/MR level of care	➢ Individuals age 16-64* ➢ Determined disabled by SSA ➢ Need assistance with the activities of daily living. ➢ Eligible for nursing facility care *Those on the waiver at the time they turn 65 may choose to stay on the waiver	➢ Children under age 22 ➢ Dependent upon intensive medical technology ➢ Medically fragile ➢ Requires the level of care provided in an acute hospital	➢ Individuals age 16-65 ➢ Have traumatic, non-degenerative brain injury resulting in residual deficits and disabilities ➢ Eligible for in-patient care in a Head Injury Rehabilitation Hospital	➢ Children 4-18; under 4 /over 18 if age exception approved ➢ Choose HCBS ➢ Determined Seriously Emotionally Disturbed by CMHC ➢ Meet admission criteria for State Hospital
Point of Entry	Preliminary Autism Application is sent to the HCBS/Autism Program Manager	Community Developmental Disability Organization	Case management Entities	Case management Entities	Case management Entities	CMHC Staff

KANSAS
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

17-8

WAIVER	AUTISM	DEVELOPMENTAL DISABILITY	PHYSICAL DISABILITY	TECHNOLOGY ASSISTED	TRAUMATIC BRAIN INJURY	SED
Financial Eligibility Rules	➢ Only the individual's personal income & resources are considered ➢ Parent's income & resources are not counted, but are considered for the purpose of determining a family participation fee ➢ Income over $727 per month must be contributed towards the cost of care	➢ Only the individual's personal income & resources are considered ➢ For individuals under age 18, parent's income & resources are not counted, but are considered for the purpose of determining a family participation fee ➢ Income over $727 per month must be contributed towards the cost of care	➢ Only the individual's personal income & resources are considered ➢ For individuals under age 18, parent's income & resources are not counted, but are considered for the purpose of determining a family participation fee ➢ Income over $727 per month must be contributed towards the cost of care	➢ Only the individual's personal income & resources are considered ➢ For individuals under age 18, parent's income & resources are not counted, but are considered for the purpose of determining a family participation fee ➢ Income over $727 per month must be contributed towards the cost of care	➢ Only the individual's personal income & resources are considered ➢ For individuals under age 18, parent's income & resources are not counted, but are considered for the purpose of determining a family participation fee ➢ Income over $727 per month must be contributed towards the cost of care	➢ Only the individual's personal income & resources are considered ➢ For individuals under age 18, parent's income & resources are not counted, but are considered for the purpose of determining a family participation fee ➢ Income over $727 per month must be contributed towards the cost of care
Services/ Supports Additional regular Medicaid services are provided	➢ Consultative Clinical and Therapeutic Services (Autism Specialist) ➢ Intensive Individual Supports ➢ Parent Support/and training ➢ Family Adjustment Counseling ➢ Respite Services ➢ **Functional Eligibility Specialist is a contracted services*	➢ Assistive Services ➢ Day Services ➢ Medical Alert Rental ➢ Sleep Cycle Support ➢ Personal Assistant Services ➢ Residential Supports ➢ Supported Employment ➢ Supportive Home Care ➢ Wellness Monitoring	➢ Personal Services ➢ Assistive Services ➢ Sleep Cycle Support ➢ Personal Emergency Response ➢ Personal Emergency Response Installation	➢ Case Management ➢ Specialized medical care (skilled nursing) ➢ Long term community care attendant ➢ Medical respite ➢ Home modifications	➢ Personal Services ➢ Assistive Services ➢ Rehabilitation Therapies ➢ Transitional Living Skills ➢ Sleep Cycle Support ➢ Personal Emergency Response ➢ Personal Emergency Response Installation	➢ Wraparound Facilitation ➢ Independent Living / Skill Building Services ➢ Parent Support and Training ➢ Short Term Respite Care ➢ Professional Resource Family Care ➢ Attendant Care

KANSAS
DEPARTMENT ON AGING

Joint Committee on Health Policy Oversight

November 5, 2010

Medicaid Summary for 2011 and 2012

Bill McDaniel

Program and Policy Commissioner

Kansas Department on Aging

Programs	2011 Total	32.23%	Caseload	2012 Total	42.56%	Caseload
CBS-FE						
Caseload Projections	$78,540,000	$25,313,442	5,950	$85,339,200	$36,320,364	6,184
2011 Appropriation/2012 Allocation	71,365,389	21,554,366		69,455,181	29,560,125	
Additional Request	7,174,611	3,759,076		15,884,019	6,760,239	

The caseload projections above include the SGF match rates changes to 32.23% in 2011 and 42.56% in 2012.
Another enhancement request is included in SFY 2012 to restore dental services, sleep cycle support, assistive technology and comprehensive supports and implement telehealth services. The total request is $7.6 million ($3.2 million SGF).

Nursing Facility						
Caseload Consensus	445,706,642	123,000,000	10,065	437,900,247	166,000,000	10,065
2011 Appropriation/2012 Allocation	373,700,000	112,857,112		445,706,642	123,000,000	
Additional Request	72,006,642	10,142,888		-7,806,395	43,000,000	

The caseload projections above include the SGF match rates changes to 32.23% in 2011 and 42.56% in 2012.
The nursing facility caseload consensus numbers include the provider assessment.

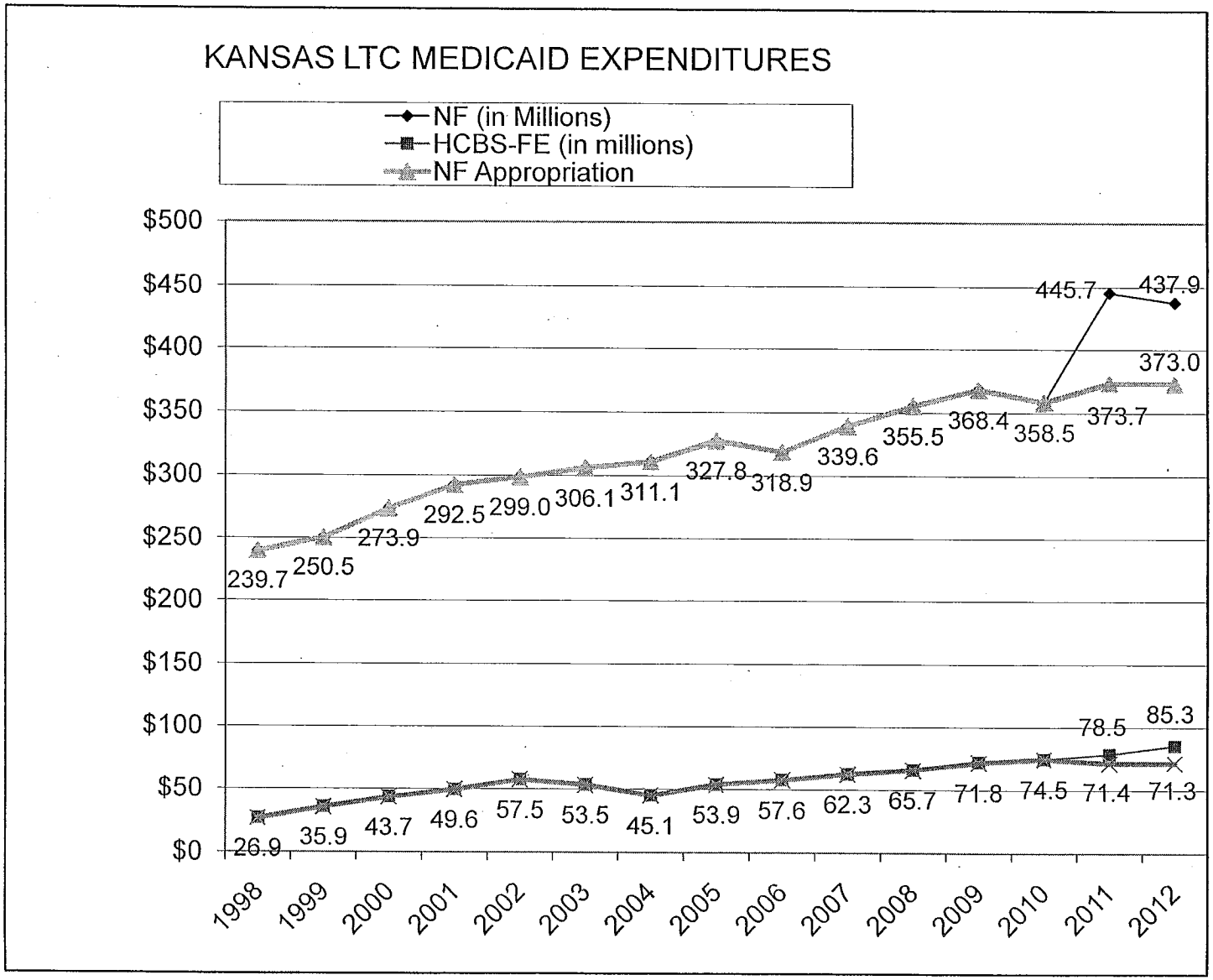
PACE						
Caseload Projections	5,310,240	1,711,490	299	6,496,500	2,764,910	355
2011 Appropriation/2012 Allocation	5,082,711	1,541,078		4,965,855	2,113,468	
Additional Request	227,529	170,412		1,530,645	651,442	

The caseload projections above include the SGF match rates changes to 32.23% in 2011 and 42.56% in 2012.
Another enhancement request includes expansion into Wyandotte and Johnson Counties with 50 slots. The total request is $915,000 ($389,424 SGF at the new match rate-42.56%).

Targeted Case Management						
Caseload Projections	5,072,712	1,634,935	4,358	5,169,173	2,200,000	4,351
2011 Appropriation/2012 Allocation	5,092,093	1,532,869		5,072,712	1,634,935	
Additional Request	-19,381	102,066		96,461	565,065	

caseload projections above include the SGF match rates
.nges to 32.23% in 2011 and 42.56% in 2012.

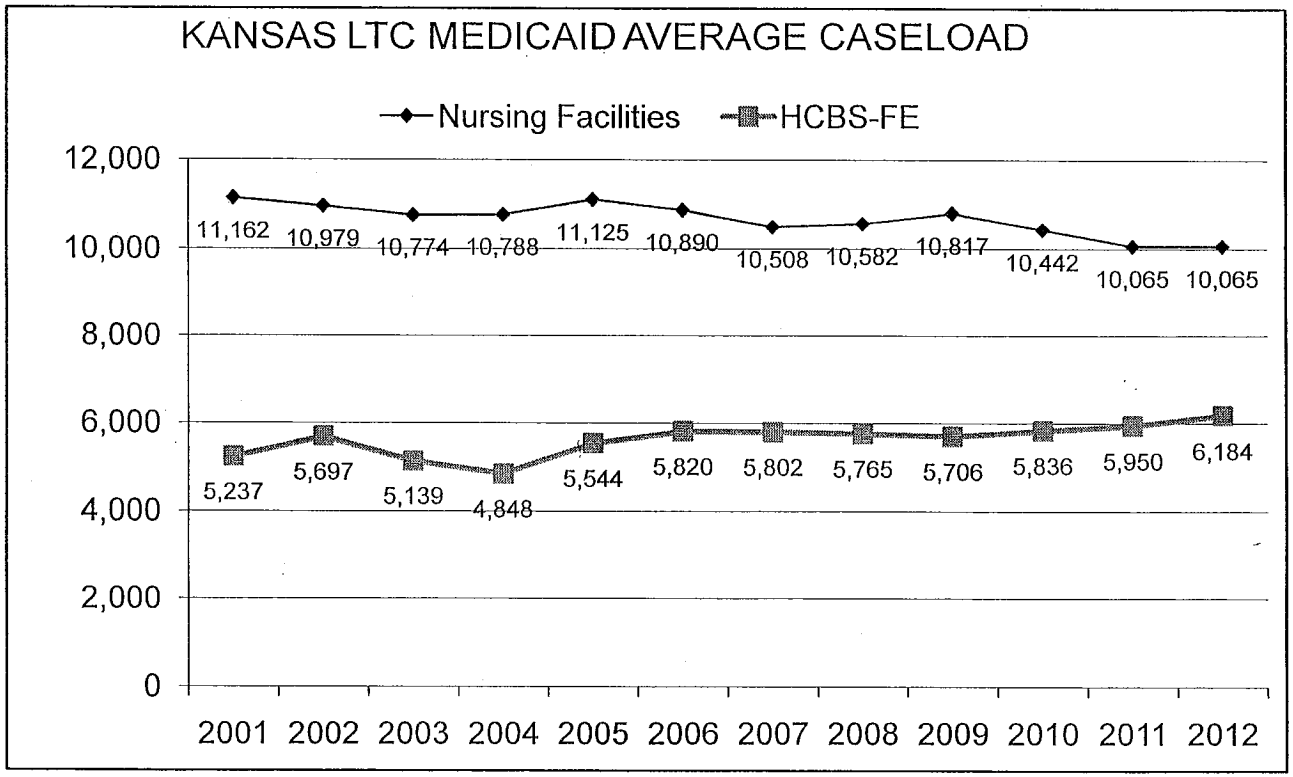
18-3



State Fiscal Years: Actual 1998 through 2010

Budget 2011 through 2012

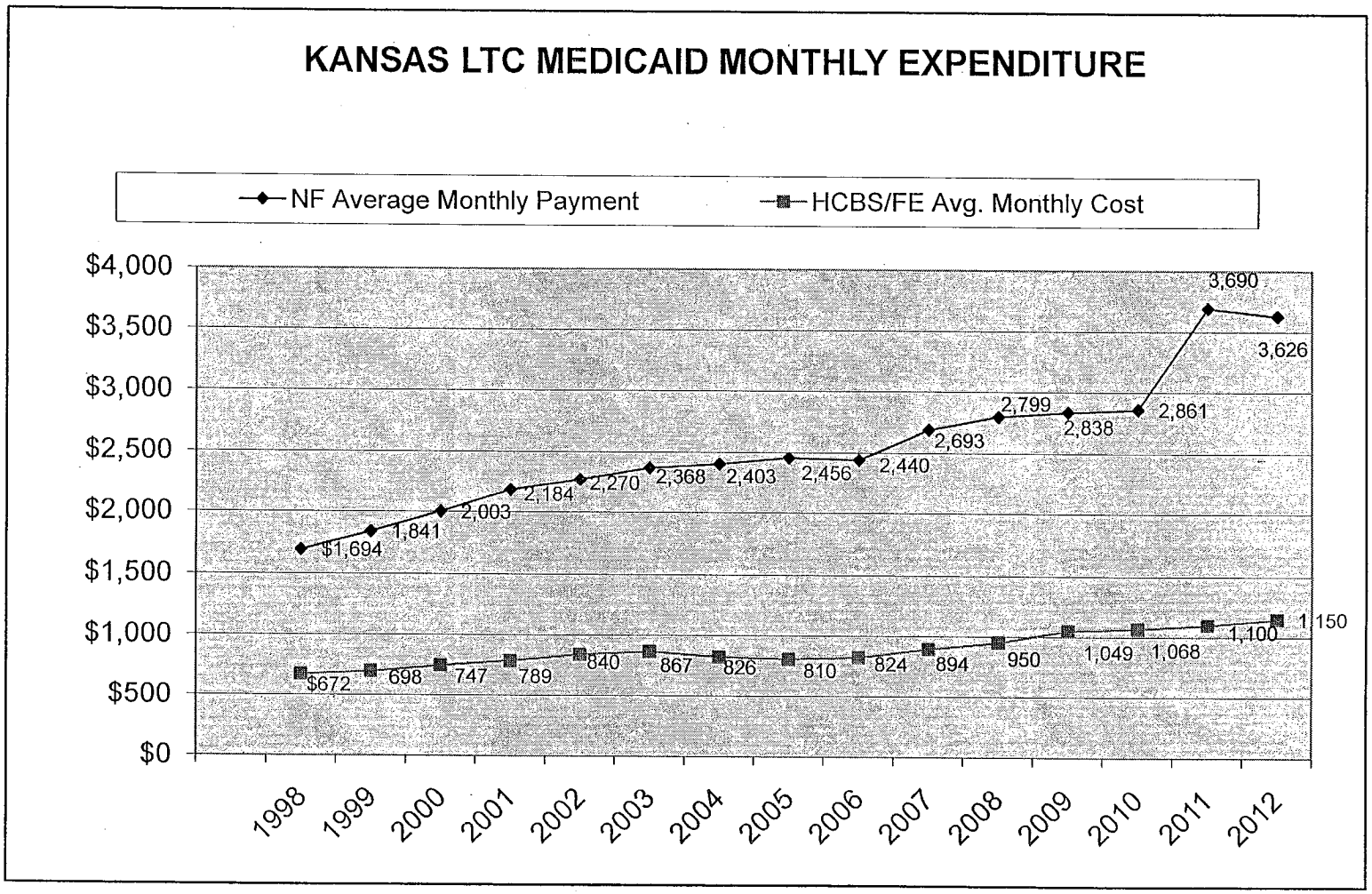
18-4



State Fiscal years: Actual 1998 through 2010

Budget 2011 through 2012

KANSAS LTC MEDICAID MONTHLY EXPENDITURE



State Fiscal Years: Actual 1998 through 2010

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Update on KHPA Budget, Caseload, and Policy Initiatives

Joint Health Policy Oversight Committee

November 5, 2010

Scott Brunner, KHPA Chief Financial Officer

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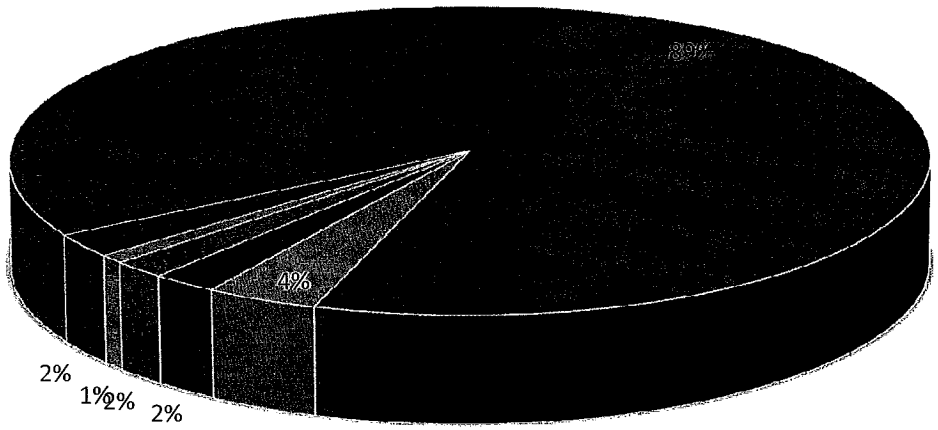
FY 2011 Revised KHPA Budget
All Funding Sources
Excluding transfers and off budget



- State Employee Health Benefits
- Medicaid Assistance
- CHIP Assistance
- Administration
- MMIS Contract
- HealthWave Clearinghouse

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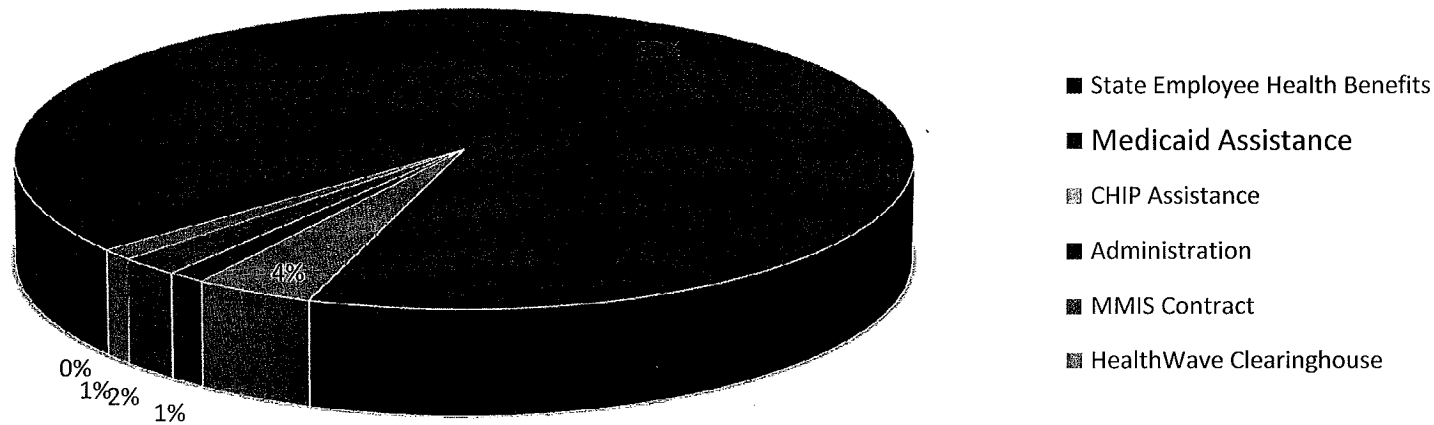
FY 2011 Revised KHPA Budget
State General Fund only



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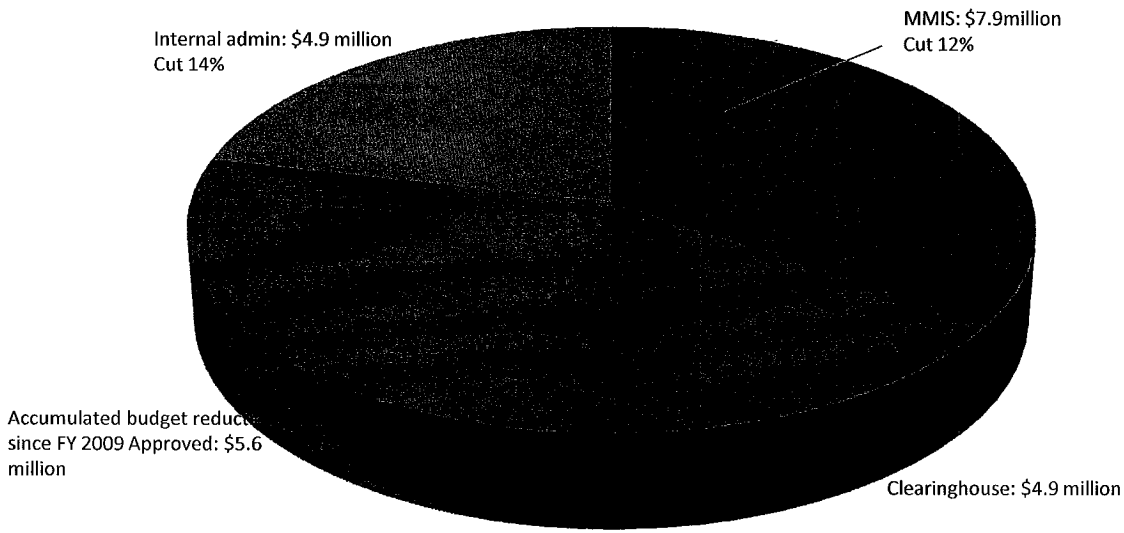
FY 2011 Submitted

State General Fund Operating Budget

$17.2 million (Cut 25% since FY 2009)



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FY 2011 – Actions to meet the approved budget

- Lay off of 7 staff
- Reduced selected staff pay
- Eliminated 20 contract employees, and replaced with 4 reallocated KHPA staff
- Froze overtime at Eligibility Clearinghouse.

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Status of FY 2012 Budget initiatives

19-6

Cost Recovery Audit Contract.

Developed a Request for Proposal to identify and collect Medicaid over-payments.

Medicaid recovery services are consistent with the forthcoming Medicaid regulations requiring states to use recovery audit services.

Other state agency programs are included in the RFP to identify potential savings from interagency and multiple service categories.

State Employee's Health Plan recoveries can be proposed.

RFP was developed with all agencies input, closed on October 29.

Expect to award the contract by December and start the contractors work by January.

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Status of FY 2012 Budget initiatives

Cost Savings/Efficiency Request for Information.

Developed a Request for Information to seek products and services from vendors that could reduce Medicaid costs.

Services are not specified, but might include care coordination, disease state management, technology and data services, etc.

Can propose products that integrate service systems or cut across Medicaid agencies.

Responses were due by October 29. Will review the policy options with the KHPA Board and Legislature.

KHPA may proceed with a Request for Proposal process to acquire services that have potential for cost savings.

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Status of FY 2012 Budget initiatives

Legislature Directed Medicaid Policy Changes

	SGF	All Funds
Eliminate coverage of certain over the counter medications	(71,260)	(200,000)
Pursue more aggressive pricing for specialty drugs in Medicaid	(94,063)	(264,000)
Limit first fill of a name brand prescription to 15 days	(84,000)	(240,000)
Reduce hospice benefits	(1,458,188)	(4,166,250)
Expand Drug Use Reviews, provider education, and peer intervention	(175,000)	(500,000)
Implement 4 brand name prescription per month limit and tiered formulary	(3,696,000)	(12,320,000)

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Status of FY 2012 Budget initiatives

19-9

HealthWave Premium Increase

2010 Legislature reduced the CHIP budget by $11.0 million ($2.8 million from the State General Fund), directing KHPA to increase premiums by $40 per family per month.

KHPA submitted the required plan amendments to CMS effective for July 1, 2010.

CMS has indicated that it will not approve the $40 premium increase.

[see separate letter from CMS]

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19-10

Medicaid Caseload

FY 2011 Revised

- Replace $30.6 million in ARRA stimulus anticipated in the approved budget for period beginning January 1, 2011.

- Observed a 7.8% increase in total expenditures from FY 2010
  - Restoration of 10% payment reduction
  - Anticipate a 3.7% increase in family enrollment, including a higher than expected growth rate through March 2011 as the application backlog is resolved.
  - Elderly and disabled population make up 49% of the expenditure increase from FY 2010.

- Account for $15.8 million from Medicaid Recovery Audits (Legislative estimate).

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19-11

Medicaid Caseload

FY 2012 Estimate

- Replace all ARRA stimulus funding.
- This includes an adjustment in state funding related to the base Federal Matching rate, which ARRA had frozen - $34.2 million compared to FY 2011.
- $14.6 million increase in state funds for Medicare Part D Clawback
- Consensus group voted to reduce State General Fund by an additional $10.0 million for second year of Medicaid Recovery Audits.

- Expecting enrollment increase of 4.7% with an average cost increase of 3.6%.
  - Disabled population make up 50% of the growth due to enrollment and cost increases.
  - KHPA increased its estimate of projected growth in the Medicaid aged and disabled populations.
  - Families make up 23% of the increase related to increased enrollment.

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Joint Committee on Health Policy Oversight
November 5, 2010

Update on HealthWave Clearinghouse Backlog

Background: In January, 1999 Kansas began modernizing its public insurance program and, with the implementation of the Children's Health Insurance Program (CHIP or HealthWave 21), initiated a simplified application for enrolling children and extended the streamlined CHIP application process to low income families applying for Medicaid. Verification requirements were loosened and eligibility was extended to children for a full twelve months. To facilitate the streamlined application process, a centralized Clearinghouse was created to receive applications via a mail-in process. Beneficiaries in eligibility categories processed by the Clearinghouse now include 40,670 children enrolled in CHIP, 178,000 children enrolled in Medicaid, 7,500 pregnant women, and 20,000 low income adults enrolled in Medicaid. The Clearinghouse now processes 10,000 to 12,000 applications and renewals a month. The remaining eligibility work, including enrollment and maintenance of elderly and medical cases and child welfare cases, remain a function performed at local offices of the Department of Social and Rehabilitation Services (SRS).

Historical Clearinghouse Performance: The Clearinghouse is a centralized processing center which manages Family Medical eligibility determinations. The Clearinghouse is operated by a private vendor through a competitive contract. The contractor for the first ten years was Maximus and now is Policy Solutions Inc. (PSI). The Clearinghouse processes applications and renewals through a mail-in process. When an application is submitted, it is registered and then forwarded to an eligibility counselor for screening. The screening process determines if any additional information is needed and if so a letter is sent to the applicant requesting the missing information. The goal at the Clearinghouse is to process the applications quickly and accurately. According to federal regulations an eligibility determination must be completed on an application within 45 days of the date it is received. Medical emergency and pregnancy related applications receive first priority for processing. On average, the Clearinghouse processed applications in less than a month prior to the institution of the new federal Medicaid citizenship and identification documentation requirements in 2006.

New federal citizenship requirements went into effect on July 1, 2006 requiring all Medicaid applicants to provide adequate documentation of citizenship and identity. The requirement of additional documentation for every applicant significantly altered the Clearinghouse application process for medical benefits. By January, 2007 a significant backlog of applications had developed, with a corresponding decline of 18,000-20,000 individuals enrolled in Kansas Medicaid and CHIP programs. KHPA made a FY 2007 supplemental budget request and a FY 2008 enhancement budget request to add staff to the Clearinghouse. The requests were approved by the legislature, and the additional

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Medicaid and HealthWave:
Phone: 785-296-3981
Fax: 785-296-4813

State Employee Health Plan:
Phone: 785-368-6361
Fax: 785-368-7180

funds were used to add 13 contract and 4 state staff. By January, 2008 applications and reviews were being fully processed within 25 days of receipt.

Contributors to Current Clearinghouse Backlog Situation: Beginning in calendar year 2009 and continuing into 2010 a number of factors converged to create a large new backlog, including:

- Increased volume of Kansans applying for Medicaid and CHIP due to economic climate
- Expiration of the HealthWave Clearinghouse contract resulting in new procurement and transition of functions from Maximus to PSI between June 2009 and January 2010
- Federal citizenship documentation requirement extended to CHIP on January 1, 2010
- Expansion of CHIP eligibility to 250% of the 2008 federal poverty level
- November 2009 Governor's Allotments resulting in a reduction of $430,000 SGF, $981,538 AF in the PSI contract
- PSI startup performance inefficiencies

Efforts to Address the Backlog. Since 2009, KHPA has taken a number of steps to find a solution to the backlog of applications and the resulting delays in eligibility experienced by thousands of applicants. In August 2009 KHPA began applying approximately $450,000 AF unexpectedly returned from a former contractor to increased overtime at the Clearinghouse. Nevertheless, as a result of the Governor's November 2009 allotment those funds had to be reapplied to other agency operations. In late 2009 and 2010 KHPA engaged in extended discussions with private donors interested in helping to reduce the backlog. Due to CMS restrictions, donations from individual Medicaid providers were limited. Nevertheless, the agency received a total of $55,000 in provider donations during FY 2010, all of which were applied to overtime for Clearinghouse staff. Beginning January, 2010, KHPA extended Medicaid and CHIP coverage for two months past the normal 12 month review redetermination. Also, in an effort to mitigate the impact of these factors on the processing of Medicaid and CHIP applications, KHPA has twice simplified the eligibility process. The first set of eligibility simplification policies were put in place January 1, 2010 and included: self-declaration of child support, elimination of trust test for "Caretaker Medical", self-declaration of pregnancy, elimination of mid-year reporting for Transitional Medical recipients, continuous 12-month eligibility for caretaker medical, change of income calculation for new applicants with jobs, and increased reliance on Department of Labor wage information. KHPA also identified several areas of performance inefficiency on the part of our Clearinghouse contractor, PSI and in addition to invoking contract penalty provisions the agency has proportioned the volume of the backlog to be attributed to PSI performance inefficiencies (8734) and assigned them sole responsibility for timely processing of those applications to them. As of October, 2010, at no additional charge to the state PSI has added 23 additional staff dedicated to processing their portion of the backlogged applications. KHPA has worked diligently in collaboration with PSI to find multidimensional approaches to reduce the backlog but despite these efforts, the backlog remained very large, prompting a federal response in mid-2010.

Addressing Centers for Medicare and Medicaid (CMS) Concerns: On April 22, 2010 KHPA received a letter from James Scott, Associate Regional Administrator for Medicaid and Children's Health Operations for CMS. In the letter, CMS noted that Kansas was out of compliance with its state Medicaid plan and with federal requirements regarding timely determination of eligibility. As a result, CMS requested the filing of a corrective action plan outlining how Kansas planned to resolve the issue. On July 30, 2010 KHPA sent to CMS the corrective action plan to resolve the HealthWave Clearinghouse backlog which employs a three-pronged approach:

- Implement system modifications to hasten the processing of applications. Many of the system enhancements have already been implemented as of November 2010. For example:

- The system's functionality has been improved by adding keyboard shortcuts, hot keys, and better search capabilities within the system;
- The system was enhanced to enable workers to make multiple month determinations at one time.
- Implementation of a single screen to create cases
- Elimination of duplicate entry by allowing entry of a case into a single system (PSI's) and transferring it to the state's eligibility system (KAECSES) overnight.

- Adopt CMS approved eligibility policy options to simplify the eligibility determination process: This represents the second wave of eligibility simplifications designed to reduce administrative burden at the Clearinghouse (and for beneficiaries). These simplifications include: KHPA will be accepting self-declaration of income; state staff will do minimum verification of the contractor's work prior to authorizing Medicaid eligibility; parents will be allowed to apply for children 18 years of age; KHPA and its contractor will perform eligibility determination only for those individuals who request coverage on the application; KHPA will initiate in phases the Express Lane eligibility option-targeting food stamp recipients first; KHPA will pursue the establishment of access to the SSA electronic verification system to confirm the declaration of citizenship with SSA records in lieu of the current presentation of citizenship documentation; KHPA will also utilize a newly developed pre-populated review form for adult beneficiaries seeking to renew their HealthWave eligibility and implement passive review determinations for child beneficiaries renewing their HealthWave eligibility. KHPA plans to fully implement these eligibility simplification policies by February 2011.

- KHPA will continue to seek financial resources from multiple sources to increase application processing capacity. Strategies include seeking private funding from philanthropic foundations, submitting budget enhancement requests to the governor and legislature and seeking a favorable CHIPRA bonus payment decision.

Current Status of HealthWave Clearinghouse Backlog: On August 11, 2010 KHPA was notified by CMS that Kansas had been awarded a $1,220.479 CHIPRA bonus award. The CHIPRA performance bonuses were included in the Children's Health Insurance Program Reauthorization law to recognize states for making significant progress in enrolling children in health coverage through Medicaid and the state children's health insurance program. Kansas was one of only ten states who received bonuses tied to the achievement of enrollment targets and improvements in the eligibility process. Kansas qualified through adoption of 12-month continuous coverage, liberalization of asset requirements, elimination of the face-to-face interview, use of a joint application for Medicaid and CHIP, and presumptive eligibility. With sufficient funding to fully implement the corrective action plan for CMS, KHPA committed to resolve the backlog within six months, i.e., by March 2011.

In the month following receipt of funding through the CHIPRA bonus, 16 temporary workers were hired as staff for the eligibility Clearinghouse. They began training on September 20, 2010. In addition, further system enhancements were implemented in September and a number of simplifications to the eligibility determination process were adopted including, streamlined verification of the contractor work, piloting of the pre-populated review form for adult beneficiaries to renew their eligibility, and exploration of implementation of the interface with SSA to confirm citizenship declaration. On October 25, 2010, KHPA initiated passive renewals for child Medicaid and CHIP beneficiaries. Over the last month the additional resources coupled with changes in policies have resulted in an increase of 5000 applications/reviews processed and a retirement of 1500 over 45

days applications from the backlog Table 1). As of November 1, the backlog numbers 17, 786 over 45 days but KHPA is now on track to resolve it by March 2011.

Figure 1

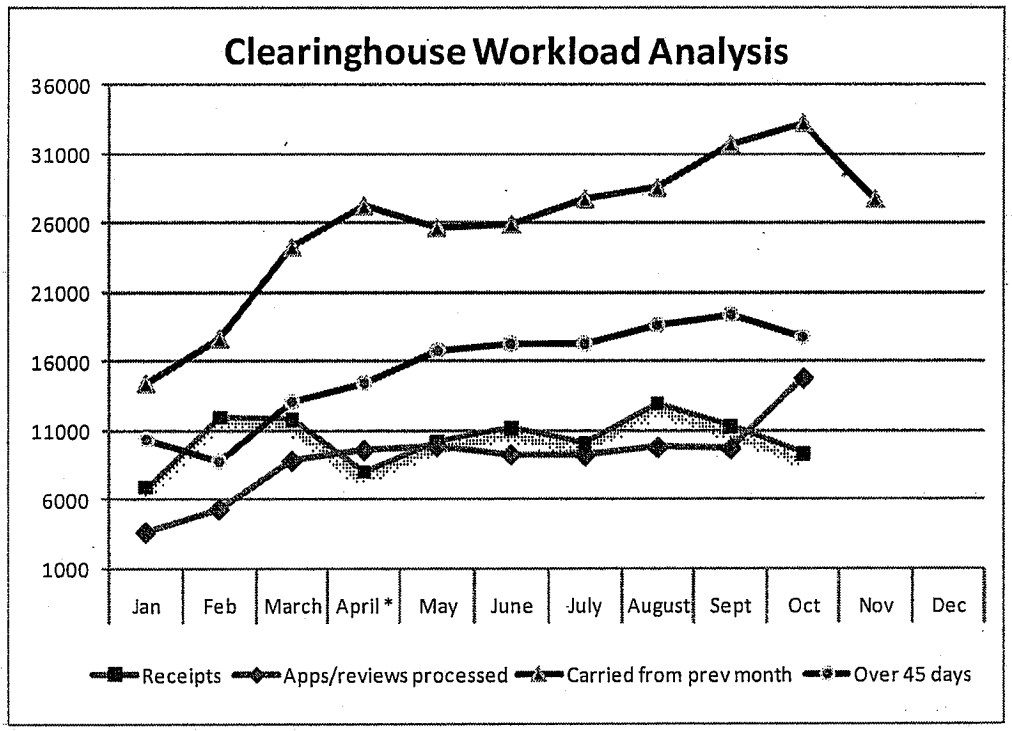

Table 1

	Jan	Feb	March	April *	May	June	July	August	Sept	Oct **	Nov	Dec	Totals
Carried from prev month	14,379	17,639	24,285	27,243	25,659	25,919	27,753	28,582	31,735	33,272	28,889		
Receipts Apps/reviews	6,902	11,969	11,810	8,015	10,146	11,132	10,026	12,965	11,250	10,438			**104,653**
Apps/reviews processed	3,642	5,323	8,843	9,599	9,886	9,298	9,197	9,812	9,713	14,821			**90,134**
Over 45 days	10,406	8,710	13,066	14,442	16,816	17,259	17,303	18,687	19,336	17,786			

* Numbers reflect Impact of the implementation of the 60 days extension for all reviews resulting in the number of reviews received per month to drop.

** Numbers reflect the addition of 16 staff as of 9/27/2010

11/2/2010

20-4

(C) Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

(i) by striking "or" at the end of clause (xii);

(ii) by inserting "or" at the end of clause (xiii); and

(iii) by inserting after clause (xiii) the following:

"(xiv) individuals described in section 1902(a)(10)(A)(i)(VIII),".

(D) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting "1902(a)(10)(A)(i)(VIII)," after "1902(a)(10)(A)(i)(VII),".

(E) Section 1937(a)(1)(B) of such Act (42 U.S.C. 1396u–7(a)(1)(B)) is amended by inserting "subclause (VIII) of section 1902(a)(10)(A)(i) or under" after "eligible under".

(b) MAINTENANCE OF MEDICAID INCOME ELIGIBILITY.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)—

(A) by striking "and" at the end of paragraph (72);

(B) by striking the period at the end of paragraph (73) and inserting "; and"; and

(C) by inserting after paragraph (73) the following new paragraph:

"(74) provide for maintenance of effort under the State plan or under any waiver of the plan in accordance with subsection (gg)."; and

(2) by adding at the end the following new subsection:

"(gg) MAINTENANCE OF EFFORT.—

"(1) GENERAL REQUIREMENT TO MAINTAIN ELIGIBILITY STANDARDS UNTIL STATE EXCHANGE IS FULLY OPERATIONAL.—Subject to the succeeding paragraphs of this subsection, during the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on the date on which the Secretary determines that an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act is fully operational, as a condition for receiving any Federal payments under section 1903(a) for calendar quarters occurring during such period, a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on the date of enactment of the Patient Protection and Affordable Care Act.

"(2) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—The requirement under paragraph (1) shall continue to apply to a State through September 30, 2019, with respect to the eligibility standards, methodologies, and procedures under the State plan under this title or under any waiver of such plan that are applicable to determining the eligibility for medical assistance of any child who is under 19 years of age (or such higher age as the State may have elected).

"(3) NONAPPLICATION.—During the period that begins on January 1, 2011, and ends on December 31, 2013, the requirement under paragraph (1) shall not apply to a State with respect to nonpregnant, nondisabled adults who are eligible for medical assistance under the State plan or under a waiver of the plan at the option of the State and whose income exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved if, on or after December 31, 2010, the State certifies to the Secretary that, with respect to the State fiscal year during which the certification is made, the State has a budget deficit, or with respect to the succeeding State fiscal year, the State is projected to have a budget deficit. Upon submission of such a certification to the Secretary, the requirement under paragraph (1) shall not apply to the State with respect to any remaining portion of the period described in the preceding sentence.

"(4) DETERMINATION OF COMPLIANCE.—

"(A) STATES SHALL APPLY MODIFIED ADJUSTED GROSS INCOME.—A State's determination of income in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3). [*As revised by section 1004(b)(1)(B) of HCERA*]

"(B) STATES MAY EXPAND ELIGIBILITY OR MOVE WAIVERED POPULATIONS INTO COVERAGE UNDER THE STATE PLAN.—With respect to any period applicable under paragraph (1), (2), or (3), a State that applies eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, applied under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, or that makes individuals who, on such date of enactment, are eligible for medical assistance under a waiver of the State plan, after such date of enactment eligible for medical assistance through a State plan amendment with an income eligibility level that is not less than the income eligibility level that applied under the waiver, or as a result of the application of subclause (VIII) of section 1902(a)(10)(A)(i), shall not be considered to have in effect eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).".

(c) MEDICAID BENCHMARK BENEFITS MUST CONSIST OF AT LEAST MINIMUM ESSENTIAL COVERAGE.—Section 1937(b) of such Act (42 U.S.C. 1396u–7(b)) is amended—

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(1) in paragraph (1), in the matter preceding subparagraph (A), by inserting "subject to paragraphs (5) and (6)," before "each";

(2) in paragraph (2)—

(A) in the matter preceding subparagraph (A), by inserting "subject to paragraphs (5) and (6)" after "subsection (a)(1),";

(B) in subparagraph (A)—

(i) by redesignating clauses (iv) and (v) as clauses (vi) and (vii), respectively; and

(ii) by inserting after clause (iii), the following:

"(iv) Coverage of prescription drugs.

"(v) Mental health services."; and

(C) in subparagraph (C)—

(i) by striking clauses (i) and (ii); and

(ii) by redesignating clauses (iii) and (iv) as clauses (i) and (ii), respectively; and

(3) by adding at the end the following new paragraphs:

"(5) MINIMUM STANDARDS.—Effective January 1, 2014, any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) must provide at least essential health benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

"(6) MENTAL HEALTH SERVICES PARITY.—

"(A) IN GENERAL.—In the case of any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) that is offered by an entity that is not a medicaid managed care organization and that provides both medical and surgical benefits and mental health or substance use disorder benefits, the entity shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

"(B) DEEMED COMPLIANCE.—Coverage provided with respect to an individual described in section 1905(a)(4)(B) and covered under the State plan under section 1902(a)(10)(A) of the services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with section 1902(a)(43), shall be deemed to satisfy the requirements of subparagraph (A).".

(d) ANNUAL REPORTS ON MEDICAID ENROLLMENT.—

(1) STATE REPORTS.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by subsection (b), is amended—

(A) by striking "and" at the end of paragraph (73);

(B) by striking the period at the end of paragraph (74) and inserting "; and"; and

(C) by inserting after paragraph (74) the following new paragraph:

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

SMD #09-005
ARRA #5

letter on CMS telephone call!

August 19, 2009

Dear State Medicaid Director:

This letter is another in a series of State Medicaid Director correspondence that provides guidance on the implementation of the American Recovery and Reinvestment Act of 2009 (the Recovery Act), Public Law 111-5. This letter provides guidance on the process for accessing the increased Federal Medical Assistance Percentage (FMAP), expenditures for which the increased FMAP is available, and the eligibility "maintenance of effort" (MOE) requirements under section 5001(f) of the Recovery Act.

Section 5001 of the Recovery Act provides eligible States with an increased FMAP for 27 months between October 1, 2008, and December 31, 2010. Under section 5001(f), to access the additional funds associated with the increased FMAP, each State must ensure that the "eligibility standards, methodologies, or procedures" under its Medicaid State Plan, or under its Medicaid waiver or demonstration programs, are not more restrictive during this period than those "in effect" on July 1, 2008. More restrictive eligibility policies would preclude the State from accessing the increased FMAP funds until the State had restored eligibility standards, methodologies, or procedures to those in effect on July 1, 2008. Furthermore, this letter reminds States that, in order to retain Recovery Act funds already drawn, any known MOE violations must have been corrected by June 30, 2009.

Background

On February 17, 2009, the Recovery Act was signed into law. The legislation authorizes an estimated $87 billion in fiscal relief for States in the form of a temporary increase in the funds that the Federal Government contributes toward Medicaid. In an effort to be responsive to public inquiries, on March 25, 2009, the Centers for Medicare & Medicaid Services (CMS) released preliminary information through a Fact Sheet and paper addressing frequently asked questions. This letter provides additional guidance and clarification, and supersedes those prior issuances.

Increased FMAP Grant Issuance

States eligible for the increased FMAP will be able to access the additional funds on an ongoing basis. At the beginning of each quarter, the estimated amount of additional funding for that quarter will be determined in accordance with the provisions of section 5001 of the Recovery Act. The estimated additional funds will be determined by calculating the difference between

the increased FMAP under the Recovery Act and the pre-Recovery FMAP, and then multiplying that difference by the estimates of appropriate expenditures submitted by each State.

Initial funding related to the increased FMAPs has been made available to States through separate grant awards issued under the Payment Management System (PMS) in accounts established specifically for the increased FMAP funds. Subsequent grant awards will be issued quarterly by the same process. The CMS grant award letters include five attestations relating to the requirements of section 5001 of the Recovery Act. The CMS grant letters direct that acceptance of the grant award and withdrawal of such funds from the PMS equates to an attestation by each State that the State is eligible for such funds, and that the expenditures for which the funding is claimed are appropriate and consistent with the requirements of section 5001 of the Recovery Act.

Required Passive Attestations Under the Grant Award

In order to minimize the need for separate review, CMS included five requirements as attestations in each grant award letter to the States. The grant award letter indicates that only after the State has conducted self-assessment and determined that it meets all the requirements under which the increased FMAP and associated funds are available, was it free to draw such funds. This process is referred to as a "passive attestation" whereby each State confirms through its withdrawal of the funds that it meets all requirements. This process obviated the need for a State to submit written confirmation that it met the requirements prior to receiving its funds; rather, the drawing of such funds represents the State's attestation that it meets all the requirements. The attestations are included as Enclosure A.

Expenditures Eligible for Increased FMAP

As indicated in the fourth attestation under the grant award, the State must ensure that claims for the increased FMAP include only those expenditures for which it is applicable. Under section 5001(e); the increased FMAP is applicable generally to title XIX, but is not applicable to certain enumerated expenditures. The following list includes those expenditures and certain others to which the increased FMAP is inapplicable for other reasons:

1. Expenditures for disproportionate share hospital (DSH) payments;
2. Expenditures for payments made under title XXI;
3. Expenditures that are claimed based on the enhanced FMAP (described in section 2105(b) of the Social Security Act);
4. Expenditures that are not paid based on the FMAP, such as family planning services;
5. Services provided through an Indian Health Service facility which are ineligible because such expenditures receive 100 percent FMAP, which is the FMAP ceiling level under section 5001(f)(5) of the Recovery Act;
6. Expenditures for medical assistance provided to individuals made eligible under a State plan or waiver with income standards (expressed as a percentage of the Federal poverty level (FPL)) higher than the income standards (as so expressed) for such eligibility as in effect on July 1, 2008; and

7. Expenditures for health care practitioner claims, or certain nursing home and hospital claims, that were received by the State during the periods in which the State is not in compliance with prompt payment standards.

In general, CMS has interpreted these exclusions narrowly. The increased FMAP is not available for expenditures for eligibility expansion populations added after July 1, 2008; to the extent that the expansion is due to higher income standards for eligibility groups for which the income standard is statutorily based on the FPL, including adding a new FPL-based eligibility group. For example, if the State raised the income standard for an eligible group from 133 to 150 percent of the FPL, expenditures for such individuals with income greater than 133 percent of the FPL would only be eligible for the regular FMAP.

Since medically needy income standards are not statutorily based on the FPL; increases in those standards would be eligible for the increased FMAP. Similarly, changes in the income standards under section 1931 of the Act would be eligible for the increased FMAP, since those standards are based on the prior levels under title IV-A.

If a State can demonstrate that an increase in an income standard was enacted under State law prior to July 1, 2008, and not effective before that date, or that the change had been submitted to CMS as a State plan amendment or waiver request, but had not yet been approved before that date, such an increase would be eligible for increased FMAP.

However, an increase in an income standard enacted under State law after July 1, 2008, or not submitted to CMS for approval until after July 1, 2008, and claims associated with those groups would not be eligible for increased FMAP. For example:

Not Eligible for Increased FMAP	Eligible for Increased FMAP
- Increases in an income level statutorily based on the FPL after June 30, 2008; AND/OR, - Addition of a new eligibility group based on the FPL after June 30, 2008.	- Increases in an income level statutorily based on the FPL enacted under State law prior to July 1, 2008, but not effective until after that date; OR, - Increases in an income level statutorily based on the FPL included in a State plan amendment or waiver request under title XIX that was pending approval by CMS on July 1, 2008; OR, - Increase in income standards, or the addition of eligibility groups that are not expressed as a percentage of the poverty line, e.g. the medically needy (irrespective of date).

The CMS intends to address the issues related to the prompt pay exclusion in separate guidance.

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Eligibility Maintenance of Effort (MOE) Requirements

Under section 5001(f)(1) of the Recovery Act, a State is not eligible for the increased FMAP if it adopts "eligibility standards, methodologies, or procedures," (referred to below as "eligibility policies") under its State plan or any waiver, that are more restrictive than those in effect on July 1, 2008. The first required passive attestation incorporated into the grant award concerns this eligibility MOE requirement. A State should first determine whether it has changed its eligibility policies from those in effect on July 1, 2008. In general, the statutory term "in effect" means the actual standards, methodologies, or procedures that States were utilizing on July 1, 2008, to determine or redetermine eligibility for Medicaid under the State plan or through a waiver program, and which are consistent with Federal statute and regulations. To the extent that a State has not changed its actual eligibility policies since July 1, 2008, there would be no eligibility MOE issue. CMS will not consider a State to have changed its eligibility policies when the State amends outdated provisions in State guidance or even in the State plan when such amendments merely codify policies that were actually in effect on July 1, 2008, and are consistent with Federal law.

If a State has changed its eligibility policies, the next question is whether those changed policies are more restrictive than those in effect on July 1, 2008. In reviewing this issue, CMS will not consider as more restrictive changes in eligibility policies that were required to comply with Federal statutes, regulations, or provisions of a State plan, demonstration, or waiver program approved as of July 1, 2008. The Recovery Act contains no language indicating that Congress intended to limit ongoing actions required to ensure compliance with program requirements. Furthermore, it is not plausible to require States to choose between the increased FMAP and potential disallowances for expenditures that were inconsistent with applicable Medicaid authorities.

Apart from compliance-related changes, CMS would consider changes in State eligibility policies to be more restrictive if the changes result in determinations of ineligibility for individuals who would have been considered eligible as of July 1, 2008. This includes changes that impose burdens on eligible beneficiaries that cause them to be determined ineligible. For example, changes in the frequency of eligibility re-determinations (for example, from 12 months to 6 months) cause eligible individuals to lose coverage and would be considered more restrictive. Similarly, increases in premiums or enrollment fees that are a condition for eligibility would be considered more restrictive. Changes in section 1915(c) waiver eligibility to replace aggregate cost neutrality with individual cost neutrality or to eliminate occupied or funded waiver capacity would also be more restrictive. More stringent institutional level of care assessments, which impact eligibility for individuals in institutional and section 1915(c) home and community based settings, are additional examples of changes resulting in more restrictive eligibility policies.

More restrictive eligibility policies would also include more restrictive income or resource standards, disability criteria, or the elimination or reduction of liberal income and/or resource methodologies under section 1902(r)(2) of the Act that had been in effect as of July 1, 2008. In addition, elimination of any eligibility group or subgroup that was included under the approved State plan or under an approved waiver as of July 1, 2008, would be viewed as more restrictive.

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For example, even if a medically needy group as a whole is still covered under the State plan, elimination of one or more categorical subgroups (e.g., the aged, or the disabled) from the group is a more restrictive eligibility policy.

Similarly, elimination of any eligibility group or subgroup authorized pursuant to 42 CFR 435.217 under a section 1915(c) waiver would be a more restrictive eligibility policy. The same would be true for elimination of a group or subgroup of individuals eligible under a title XIX demonstration project pursuant to section 1115 of the Act, including combination title XIX and title XXI demonstrations, except to the extent that the demonstration involved a separate title XXI program demonstration, to which title XXI rules apply.

Importantly, reductions in waiver slots under section 1915(c) waivers may be considered MOE issues because of the direct relationship between enrollment in a 1915(c) waiver and Medicaid eligibility for the individuals described in 42 CFR 435.217. In particular, reductions in the maximum number of waiver slots in an approved waiver would only be consistent with the Recovery Act MOE requirements if the State can demonstrate that the number of waiver slots available is the higher of the number of waiver slots that were occupied as of July 1, 2008, or the number the State legislature actually funded as of that date. Any such changes must be expressly identifiable in State law. Funding may not be reduced to a level below that which was available on July 1, 2008.

More restrictive eligibility policies would also include changes in eligibility procedures that are not reflected in an approved State plan or approved waiver document. Therefore, CMS may not be aware of an MOE issue in a State unless either the State or other concerned parties alert CMS to the issue. For this reason, each State must review its own eligibility policies to determine if there is a change, and if it is more restrictive. CMS will continue to work with States to provide technical assistance to determine the necessary action to assure compliance with approved State plans, waiver programs and the Recovery Act requirements throughout the period ending on December 31, 2010.

Program modifications that do not directly affect eligibility are not subject to the eligibility MOE requirements. These modifications include changes to the post-eligibility application of patient income to the cost of institutional or other long-term care, modifications to provider payment rates, modifications to the benefit package that would eliminate optional benefits, or imposition or increase of co-payments or co-insurance with respect to a covered service.

Reinstatement of Provisions Which Exclude the State from Receiving the Increased FMAP

The increased FMAP is available to eligible States for a 27-month period between October 1, 2008, and December 31, 2010. As such, CMS will continue to work with States to determine initial and on-going eligibility for the increased FMAP. States may regain eligibility for the increased FMAP effective back to October 1, 2008, if they reversed those Medicaid eligibility restrictions which made them ineligible for the increased FMAP on or before June 30, 2009. After June 30, 2009, however, the eligibility for the increased FMAP is only effective prospectively, with the first calendar quarter the State reverses the eligibility restriction(s). States should send written communication to their CMS Regional Office describing the

identified eligibility restriction(s) and the steps the State will take to reverse such restriction(s). States must include an effective date for those reinstatements. If State plan amendments, waiver amendments, or other official documents must be prepared and otherwise adjudicated in order to officially reinstate the previous policy, CMS will accept a letter indicating that the eligibility restriction(s) has in fact been reinstated, and the effective date(s) it was reinstated, as sufficient documentation to regain the State's eligibility for the increased FMAP. Conforming State plan(s), waiver(s), or other official documents must be submitted by the State within a reasonable time period.

Included with this letter is also an enclosure which provides some examples of what would constitute a restriction to eligibility standards, methodologies, or procedures.

If you have questions regarding this guidance, please contact Mr. Bill Lasowski, Deputy Director, Center for Medicaid and State Operations who may be reached at (410) 786-2003.

Sincerely,

/s/

Cindy Mann
Director

Enclosures

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

Ann C. Kohler
NASMD Executive Director
American Public Human Services Association

Joy Wilson
Director, Health Committee
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Subtitle E—Affordable Coverage Choices for All Americans

PART I—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

Subpart A—Premium Tax Credits and Cost-sharing Reductions

SEC. 1401. REFUNDABLE TAX CREDIT PROVIDING PREMIUM ASSISTANCE FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by inserting after section 36A the following new section:

"SEC. 36B. REFUNDABLE CREDIT FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

"(a) IN GENERAL.—In the case of an applicable taxpayer, there shall be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the taxpayer for the taxable year.

"(b) PREMIUM ASSISTANCE CREDIT AMOUNT.—For purposes of this section—

"(1) IN GENERAL.—The term 'premium assistance credit amount' means, with respect to any taxable year, the sum of the premium assistance amounts determined under paragraph (2) with respect to all coverage months of the taxpayer occurring during the taxable year.

"(2) PREMIUM ASSISTANCE AMOUNT.—The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of—

"(A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152) of the taxpayer and which were enrolled in through an Exchange established by the State under 1311 of the Patient Protection and Affordable Care Act, or

"(B) the excess (if any) of—

"(i) the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer, over

"(ii) an amount equal to 1/12 of the product of the applicable percentage and the taxpayer's household income for the taxable year.

"(3) OTHER TERMS AND RULES RELATING TO PREMIUM ASSISTANCE AMOUNTS.—For purposes of paragraph (2)—

"(A) APPLICABLE PERCENTAGE.—

"(i) IN GENERAL.—[*As revised by section 1001(a)(1)(A) of HCERA*] Except as provided in clause (ii), the applicable percentage for any taxable year

shall be the percentage such that the applicable percentage for any taxpayer whose household income is within an income tier specified in the following table shall increase, on a sliding scale in a linear manner, from the initial premium percentage to the final premium percentage specified in such table for such income tier:

definition of affordability *

"In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is—	The final premium percentage is—
Up to 133%	2.0%	2.0%
133% up to 150%	3.0%	4.0%
150% up to 200%	4.0%	6.3%
200% up to 250%	6.3%	8.05%
250% up to 300%	8.05%	9.5%
300% up to 400%	9.5%	9.5%

"(ii) INDEXING.—[*As added by section 1001(a)(1)(B) of HCERA instead of clauses (ii) and (iii) previously here*]

"(I) IN GENERAL.—Subject to subclause (II), in the case of taxable years beginning in any calendar year after 2014, the initial and final applicable percentages under clause (i) (as in effect for the preceding calendar year after application of this clause) shall be adjusted to reflect the excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year.

"(II) ADDITIONAL ADJUSTMENT.—Except as provided in subclause (III), in the case of any calendar year after 2018, the percentages described in subclause (I) shall, in addition to the adjustment under subclause (I), be adjusted to reflect the excess (if any) of the rate of premium growth estimated under subclause (I) for the preceding calendar year over the rate of growth in the consumer price index for the preceding calendar year.

"(III) FAILSAFE.—Subclause (II) shall apply for any calendar year only if the aggregate amount of premium tax credits under this section and cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act for the preceding calendar year exceeds an amount equal to 0.504 percent of the gross domestic product for the preceding calendar year.

"(B) APPLICABLE SECOND LOWEST COST SILVER PLAN.—The applicable second lowest cost silver plan with respect to any applicable taxpayer is the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides which—

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"(i) is offered through the same Exchange through which the qualified health plans taken into account under paragraph (2)(A) were offered, and

"(ii) provides—

"(I) self-only coverage in the case of an applicable taxpayer—

"(aa) whose tax for the taxable year is determined under section 1(c) (relating to unmarried individuals other than surviving spouses and heads of households) and who is not allowed a deduction under section 151 for the taxable year with respect to a dependent, or

"(bb) who is not described in item (aa) but who purchases only self-only coverage, and

"(II) family coverage in the case of any other applicable taxpayer.

If a taxpayer files a joint return and no credit is allowed under this section with respect to 1 of the spouses by reason of subsection (e), the taxpayer shall be treated as described in clause (ii)(I) unless a deduction is allowed under section 151 for the taxable year with respect to a dependent other than either spouse and subsection (e) does not apply to the dependent.

"(C) ADJUSTED MONTHLY PREMIUM.—The adjusted monthly premium for an applicable second lowest cost silver plan is the monthly premium which would have been charged (for the rating area with respect to which the premiums under paragraph (2)(A) were determined) for the plan if each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such silver plan and the premium was adjusted only for the age of each such individual in the manner allowed under section 2701 of the Public Health Service Act. In the case of a State participating in the wellness discount demonstration project under section 2705(d) of the Public Health Service Act, the adjusted monthly premium shall be determined without regard to any premium discount or rebate under such project.

"(D) ADDITIONAL BENEFITS.—If—

"(i) a qualified health plan under section 1302(b)(5) of the Patient Protection and Affordable Care Act offers benefits in addition to the essential health benefits required to be provided by the plan, or

"(ii) a State requires a qualified health plan under section 1311(d)(3)(B) of such Act to cover benefits in addition to the essential health benefits required to be provided by the plan,

the portion of the premium for the plan properly allocable (under rules prescribed by the Secretary of Health and Human Services) to such additional benefits shall not be taken into account in determining either the monthly premium or the adjusted monthly premium under paragraph (2).

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CHIP Cost sharing:

From Sec 2103 of the SS Act (42 U.S.C. 1397cc)

(e) Cost-sharing.—

(1) Description; general conditions.—

(A) Description.—A State child health plan shall include a description, consistent with this subsection, of the amount (if any) of premiums, deductibles, coinsurance, and other cost sharing imposed. Any such charges shall be imposed pursuant to a public schedule.

(B) Protection for lower income children.—The State child health plan may only vary premiums, deductibles, coinsurance, and other cost sharing based on the family income of targeted low-income children in a manner that does not favor children from families with higher income over children from families with lower income.

(2) No cost sharing on benefits for preventive services or pregnancy-related assistance[25].—The State child health plan may not impose deductibles, coinsurance, or other cost sharing with respect to benefits for services within the category of services described in subsection (c)(1)(D) or for pregnancy-related assistance[26].

(3) Limitations on premiums and cost-sharing.—

(A) Children in families with income below 150 percent of poverty line.—In the case of a targeted low-income child whose family income is at or below 150 percent of the poverty line, the State child health plan may not impose—

(i) an enrollment fee, premium, or similar charge that exceeds the maximum monthly charge permitted consistent with standards established to carry out section 1916(b)(1) (with respect to individuals described in such section); and

(ii) a deductible, cost sharing, or similar charge that exceeds an amount that is nominal (as determined consistent with regulations referred to in section 1916(a)(3), with such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable).

(B) Other children.—For children not described in subparagraph (A), subject to paragraphs (1)(B) and (2), any premiums, deductibles, cost sharing or similar charges imposed under the State child health plan may be imposed on a sliding scale related to income, except that the total annual aggregate cost-sharing with respect to all targeted low-income children in a family under this title may not exceed 5 percent of such family's income for the year involved.

5%

JOINT COMMITTEE ON HEALTH
POLICY OVERSIGHT
DATE: 11-5-10
ATTACHMENT: 24