MINUTES

JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT

December 8-9, 2010
Room 548-S-Statehouse

Members Present

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

Staff Present

Kathie Sparks, Kansas Legislative Research Department
Amy Deckard, Kansas Legislative Research Department
Nobuko Folmsbee, Office of the Revisor of Statutes
Renae Jefferies, 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

Barb Langner, Kansas Medicaid Director, Kansas Health Policy Authority
Dr. Andrew Allison, Executive Director, Kansas Health Policy Authority
Dr. Lee Ann Bell, State Pharmacist, Kansas Health Policy Authority
Sandy Praeger, Insurance Commissioner, Kansas Insurance Department
Jane Adams, Executive Director, Keys for Networking
Randy Bowman, Director of Community Programs, Juvenile Justice Authority
Cathy Harding, Executive Director, Kansas Association for the Medically Underserved
Betty Wright, Executive Director, Kansas Dental Board
Kevin Robertson, Executive Director, Kansas Dental Association
Lawless Barrientos, Public Affairs Director, Comfort Dental
Dr. Craig Bahr, Dentist

Others Attending

See attached list.

Wednesday, December 8
Morning Session

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

Representative Bethell made a motion to approve the minutes of the November 4-5, 2010, meeting of the Joint Committee on Health Policy Oversight. Representative Mast seconded the motion. The motion passed.

Barb Langner, Kansas Medicaid Director, Kansas Health Policy Authority (KHPA), provided an overview of the updates on issues from the November meeting to be presented (Attachment 1).

One of the first topics addressed was the letter from Centers for Medicaid and Medicare Services (CMS) dated November 16, 2010 (Attachment 2) in response to KHPA's letter of November 24, 2009, concerning Kansas' ability to comply with Section 403 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 explaining that state legislation will be required in order for Kansas to meet the disenrollment requirement. The letter from KHPA indicated the agency has notified CMS that it presented testimony explicitly identifying the requirements of CHIPRA Section 2103(f) on December 17, 2009, to the Joint Committee on Health Policy Oversight; on February 3, 2010, to the Senate Ways and Means Committee; and on March 2, 2010, to the House Social Service Budget Committee. Despite these efforts, the Legislature did not choose to introduce legislation to address this issue during its 2010 session.

CMS indicated it sent the most recent letter to reiterate the need for the state to make a good faith effort to comply with the CHIPRA Section 2103(f) requirements. KHPA is encouraged to do this by continuing to pursue modification of state law during the 2011 Legislative Session. Section 3(d)(2) of CHIPRA provides that federal financial participation (FFP) shall not be denied to a state which makes a good faith effort to comply with the requirements prior to the issuance of any guidance or regulations implementing the provision in question.

CMS encourages Kansas to continue monitoring this managed care entity's network adequacy considering CHIP enrollment, expected utilization of services and panel restrictions in areas where there are limited providers and appreciates Kansas taking the necessary actions to promote access and choice within the plan.

CMS invites Kansas to share with CMS any additional challenges that compliance with CHIPRA Section 2103(f) poses to Kansas. CMS would be interested to learn of any difficulties the state expects to encounter in complying with the managed care disenrollment requirements in rural and frontier areas. CMS is particularly concerned that abruptly changing the State's enrollment practices for these families may cause disruptions or gaps in health care coverage.

CMS appreciates Kansas taking the necessary actions to minimize disruption of coverage for these families while waiting for enabling legislation.

Following the discussion of the CMS letter, the following two items were discussed in the morning session:

- A chart outlining the time line for all pharmacy changes (Attachment 3); and

- Senate Sub. for HB 2631 instructed KHPA to reduce the number of brand name drugs allowed from five to four, and the Committee had questioned what might be saved from reducing that limit to two. The following response was provided:

  - The FY 2011 budget included $12 million (all funds) savings associated with reducing the brand limit and implementing a tiered co-pay; the savings projected in the legislative budget bill was based on an increase in the generic dispensing rate (*i.e.,* how often a generic medication is dispensed vs a brand-name), rather than directly as a result of the policy changes themselves. KHPA is hesitant to project additional short-run savings (FY 2012-2013) that might result from a further reduction of brand name drugs allowed from four down to two. It is our understanding that the savings proposed by the legislature was estimated by what could be saved if the generic dispensing rate for Kansas Medicaid was as high as that of neighboring Oklahoma Medicaid, 4.4 percent higher. Kansas and Oklahoma have a different set of pharmacy policies that contribute to the overall rate of generic dispensing. The brand limit utilized by Oklahoma Medicaid is two per calendar month, with only cancer, HIV, and oral contraceptives exempted. Since this year's budget already assumes Kansas will reach Oklahoma's generic dispensing rate, reducing the number of brand name prescriptions allowed in Kansas to the number allowed in Oklahoma is not anticipated to result in a higher generic dispensing rate than that experienced by Oklahoma.

    In addition to a two brand limit, Oklahoma utilizes a tiered formulary system. Counter-intuitively, implementation of a tiered formulary in Kansas would result in a short-term increase in Medicaid expenditures. This is caused by a difference in federal co-pay requirements between tiered and non-tiered programs. For all providers, any patient co-pay amount is subtracted from the payment to the provider. For example, a $10.00 pharmacy claim with a $3.00 co-pay amount results in a $7.00 Medicaid payment to the pharmacy. Under federal requirements for tiered formularies, a $10.00 pharmacy claim is allowed a co-pay of no more than $0.60. The Medicaid payment to the pharmacy for a $10.00 claim in a tiered formulary is therefore $9.40, an increase of $2.40 over the payment in our current system. Over 70 percent of pharmacy claims would result in a higher cost-sharing requirement for Medicaid. We estimate this would result in an expenditure increase of $1.0 million in the first fiscal year. The increase in expenditures could likely be recouped from the migration to lower-cost products caused by tiered formularies by inducing more prescriptions for $10 dollar generic drugs and fewer $50 dollar brand name drugs, but not within one fiscal year as this requires a change in physician prescribing patterns.

Dr. Lee Ann Bell responded to questions concerning the potential savings. She said the reason the agency does not think it would provide any extra savings to change from the four

brand limit to a two brand limit, is that we would not expect Kansas' dispensing rate to go lower then what Oklahoma's currently is, which is how the savings was calculated. She indicated if Kansas could change our generic dispensing rate from 64 percent to 68 percent, it could expect to save the $12 million. But the questions are what policy changes would have to be made to achieve that dispensing rate. Only a change in prescribing and use patterns results in increased savings.

The Committee requested information on the current dispensing rate and what has been the historic trend in dispensing rates, so it can determine if the generic dispensing rate has increased or decreased and then analyze potential reasons for the increase or decrease in the generic dispensing rate. The question was asked what dollars are received in rebates now in name brand drugs and generic drugs. In addition, if the change were to be made to dispense increased generic drugs, what would be the change in rebate level (name brand) and supplemental rebate level (generic drugs). Dr. Bell indicated KHPA can provide that information.

Chairperson Landwehr reiterated the importance to KHPA of providing detailed information for the Committee to review in response to questions and the Committee was disappointed in the level of response provided to this question.

Doug Farmer, Director of State Employees Health Care, responded to questions and indicated they were given a list of options and associated potential savings numbers last session by the House Appropriations and Senate Ways and Means committees to review during the Omnibus Session. The numbers on potential savings were provided by an outside firm and, after analyzing the information, they could not verify that changing to two brand names would achieve the $12 million dollar savings. There may be more things that need to be changed in the Pharmacy Program to hit the $12 million. The Committee requested KHPA provide the name of the consultant used to project the $12 million at a future time, as it could not be provided at the meeting.

Ms. Langner responded to the question of formulating a mental health advisory group to provide a better educational program so that mental health drugs would be prescribed appropriately. There has been difficulty in achieving funding for the program. A letter was sent requesting financial assistance and the Committee requested a copy of the letter and a list of the recipients of the letter.

Dr. Andrew Allison, Executive Director, KHPA, responded to additional questions concerning the status of rules and regulations and indicated the feedback received was very helpful and the goal was to streamline processes. KHPA also was asked to provide information as to how many requests for proposals were out and scheduled to be awarded prior to January 10, 2011. Senator Schmidt presented a number of questions and Dr. Allison indicated the agency would get back to her.

Representative Bethell inquired as to what the current proposal before the Joint Committee on Rules and Regulations does in regard to certain mental health medications. Dr. Bell indicated it does not impact them at all; they have a statutory restriction, so they will not be using this process on any of the mental health drugs. Dr. Allison indicated they will respond in writing as to how the process works and to explain why the proposal has been made.

The meeting recessed at 11:45 a.m.

Afternoon Session

Chairperson Landwehr reconvened the meeting at 12:10 p.m. as a working lunch.

Insurance Department Presentation

Sandy Praeger, Insurance Commissioner, Kansas Insurance Department (KID), reviewed an educational presentation to the Committee (Attachments 4 and 5).

Commissioner Praeger began by showing the Department website and its links to the national health website. She provided the following information:

- Kansas Statistics – 2.8 million people in Kansas. Approximately 50 million people in the U.S. do not have health coverage (16.2 percent of the population). In Kansas, the number of uninsured is 340,000 or 12.5 percent of the population.
    - Nearly 88 percent of Kansans are insured (83 percent nationally);
    - 13.8 percent have Medicare (14.1 percent nationally); and
    - Ages 19-64 (2007-2008):
        - 65.8 percent of Kansans have employer-based coverage (63 percent nationally)
        - 8 percent have individual coverage;
        - 5.7 percent have Medicaid;
        - 4.6 percent have other public insurance (Tri-Care); and
        - 16 percent are uninsured.

- Federal healthcare reform was enacted on March 23, 2010, as the Patient Protection and Affordable Care Act of 2010 (H.R. 3590). On March 30, 2010, President Obama signed the Reconciliation Act (H.R. 4872). This legislation amends the Patient Protection Act to: 1) increase subsidies for low-income persons and penalties on employers; 2) phase-out the "doughnut hole" in Medicare Prescription Drug coverage; and 3) modify tax provisions.

- High Risk Pool Grants—Kansas received $36 million for individuals who currently do not have coverage and have a pre-existing condition. There are currently 121 enrollees.

- Health Plan Reforms (as of September 23, 2010) included no lifetime limits and first-dollar coverage for preventive services, no rescissions, an appeals process, dependent coverage up to 26 years of age, and no pre-existing condition exclusions for children.

- Grants for: consumer assistance to states for education and outreach; rate review; and Exchange planning. There is an early retiree reinsurance program and rebate programs beginning January 1, 2011, for medical loss ratio.

- Market Reforms: guarantee issue and no pre-existing condition exclusions in all markets; rating reforms limiting factors to age, geography, tobacco use and family composition; and no annual limits.

- Small Business Tax Credit: businesses with 25 or fewer employees; average wages less than $50,000; contribute at least 50 percent of premium; phases out as size and wages of business increase; 2010-2013: up to 35 percent of total employer contribution; 2014 and later: up to 50 percent of contribution.

- Key Reforms—2014 Implementation: State-based Exchanges for individual and Small Group markets (fewer than 50 employees) that will provide standardized information on insurance choices and help consumers enroll in plans.
    - Individual mandate to ensure consumers do not wait until they are sick to seek coverage;
    - Penalties for no coverage (whichever is greater):
        - 2014 - $95 or 1 percent of household income;
        - 2015 - $325 or 2 percent of household income.
        - 2016 - $695 or 2.5 percent of household income; and
        - Annual increase after 2016.

- Large Employer Responsibility (50 or More FTEs): If employer fails to offer minimum coverage and one of its employees receives a subsidy through the Exchange, the employer will be subject to a penalty of $2,000 per employee. If an employer offers coverage but an employee receives a subsidy through the Exchange, the employer will be subject to a penalty of $3,000 per employee receiving a subsidy.

- KID Working Groups: Grant applications, rate and form filing review, high risk pool, consumer Ombudsman work, Exchange planning/coordination, data collection, and IT architecture.

- NAIC Working Groups: 14 total including standardized definitions and uniform explanation of coverage.

- KID Response Initiatives: Regular updates on implementation and consumer/ business information posted on www.ksinsurance.org (special section on health reform with links to other sites) and www.healthcare/gov with national web portal.

The Kansas Insurance Department goal in federal health reform is to work for the best possible outcomes for Kansas consumers, Kansas agents and Kansas companies by keeping reforms at the state level.

Exchange Statutory Timelines

- Each state shall establish an American Health Benefit Exchange by January 1, 2014. This includes individual market and small group market Exchanges, which may be combined.

- Small groups are defined as 1-100 employees. The State may elect to define as 1-50 until January 1, 2016. The State may elect to combine individual and small group markets.

- The Secretary of HHS must certify by January 1, 2013, that a state will be able to operate a qualified Exchange. If a state does not, the federal government will operate it.

Federal Exchange Grants

- Initial planning grants (awarded October 2010):
  - $1 million to 48 states and District of Columbia for research and planning including market analysis, development of governance and operational framework, IT assessment, stakeholder outreach, staffing, and funding requirements; and
  - Establishment Grants – Details to be announced in Spring 2011.

Exchanges

- Must be operated by a governmental agency or nonprofit entity established by a state; and

- Legislature must enact laws for creation and implementation of Exchange.

Key Decision Points: Governance, Additional Functions of the Exchange, Additional Information for Consumers, Regulation of the Outside Market, Mandated Benefits, Funding of Operations and Role of Agents.

Role of Agents

- States may allow agents and brokers to assist individuals and employers to enroll in qualified health plans in the Exchange and assist individuals in applying for premium tax credits and cost sharing reductions for plans in the Exchange; and

- States will establish compensation structure for agents and brokers.

Role of State Agencies

- Department of Insurance (licensure, certification, market conduct, and enforcement); and

- KHPA will determine Medicaid and CHIP eligibility determinations and enrollment.

Individual and Small Group Exchanges

- Individuals may enroll in any qualified health plan offered in state Exchange; and

- Employees have choice of carrier. Employer may choose coverage level. Employees choose from carriers offering at the level. Employees individually rated (limited to four allowed rating factors).

Levels of Coverage

- Bronze – covers 60 percent of actuarial value of benefits;

- Silver – covers 70 percent of actuarial value of benefits;

- Gold – covers 80 percent of actuarial value of benefits;

- Platinum – covers 90 percent of actuarial value of benefits; and

- Catastrophic – high-deductible plan for young (under age 30) and those exempt from individual mandate.

Exchange Functions

At a minimum, an Exchange must:

- Operate a toll-free hotline for consumer assistance;

- Maintain an Internet website with comparative information about available qualified plans;

- Certify qualified plans to be made available to individuals or employers (dental plans can be included);

- Inform individuals of eligibility for Medicaid and CHIP and enroll them in such programs;

- Make available a calculator to determine the actual cost of coverage after application of premium tax credits and cost sharing reductions;

- Grant a certification attesting that the individual is not subject to the coverage mandate because there is no affordable health plan available or the individual is exempt from the mandate;

- Transfer to the U.S. Treasury Department a list of exempt individuals and employees eligible for premium tax credit; and

- Establish a Navigator program where the Exchange will award grants to entities such as trade/industry groups, professional associations, farming organizations, consumer nonprofit groups, and chambers of commerce who will educate consumers and assist with enrollment in qualified health plans.

Qualified Health Plans Must:

- Be offered by a licensed insurance company;
- Insure a sufficient choice of medical providers;
- Provide information to the public regarding the quality of the plan;
- Provide Essential Benefits as defined by HHS;
- Agree to offer at least one Silver and one Gold plan;
- Agree to charge same price in and out of Exchange; and
- Utilize standardized format for presenting plan options.

The Kansas Insurance Department provided Kansas consumer education activities regarding the Affordable Care Act from March through November 2010 as follows (Attachment 6):

- 97 Kansas journalist media interviews (just Kansas—probably three times that many, nationally);
- Six KID-written articles in *Kansas* magazine;
- Two monthly statewide Commissioner's Corner columns;
- Two news releases on health reform topics;
- Three consumer alert news releases on health reform topics;
- Three KID Insurance Quarterly electronic magazine articles on health reform topics;
- 900-1000 (estimated) Consumer Assistance Division public calls for health care reform assistance/understanding;
- Seventeen KID booth exhibits with information on health reform;
- Ten days of State Fair presence with specific health reform pamphlets;

- Two informational meetings on health care reform, in Hays on November 20 and Overland Park on November 23; and

- www.ksinsurance.org – special section on website, up since April, updated regularly.

A chart showing Health Care Reform NAIC/Commissioner Responsibilities as of April 2010, was provided (Attachment 7). The chart included issues, responsibilities, time lines and citation for each issue. (NAIC is the National Association of Insurance Commissioners.)

KHPA Update

Dr. Allison, KHPA, returned to the meeting to update the Committee on the following:

- A press release dated December 8, showing KHPA awarding the recovery audit contract to Health Data Insights (Attachment 8);

- In follow-up to a question at the morning session, a list of current KHPA RFPs was distributed (Attachment 9). The RFPs included: Recovery Audit Contractor, State Medicaid HIT Plan Development, Automated Prior Authorization, Health Reform Options and Kansas Medical Eligibility Determination;

- The Clearinghouse Workload Analysis Chart (Attachment 10). Dr. Allison noted KHPA was surprised at the large increase of applications received in November 2010. There were questions related to what percentage of the applications are Medicaid and what percentage are HealthWave, since Medicaid is retroactive, but HealthWave is not. Dr. Allison responded the agency will get back to the Committee concerning this question.

- Whether an explanation of benefits is given to Medicaid recipients and whether notification for payment of services to consumers is provided, the following was received:

    - The Single State Medicaid Agency is required to have a method for verifying with recipients whether services billed by providers were received (42 CFR 455.20 (a)). KHPA currently sends Explanations of Medical Benefits (EOMB) to 400 randomly selected fee-for-service recipients each month. In an informal survey of states conducted in January of 2009 through the National Association for Medicaid Program Integrity list serve, 14 of the states responded to the questions related to methodology used to issue EOMBs. Their responses indicated that they also were sending EOMBs to a sample of their recipient population.

- In response to the question is there a way to measure the advantage of providing consumers with notification that a service has been paid for on their behalf, the following was provided:

    - KHPA tracks the number of responses received as a result of the letters and any needed corrective action. In 2009, we received inquiries on 2.7 percent of the letters sent and 1.6 percent of the claims were questioned. From

January through October 2010, we received inquires on 1.4 percent of the letters sent and 0.07 percent of the claims were questioned.

- In response to the question what percentage of beneficiary's charts are reviewed for appropriate services, the following was provided:
  - KHPA conducts monthly chart evaluation as part of its utilization review processes and uses Surveillance and Utilization Review Subsystem (SURS), which is federally mandated to monitor providers and consumers of Medicaid services. SURS performs post-payment provider review, consumer reviews and data analysis to safeguard against unnecessary or inappropriate use of services and against excess payments, assess the quality of services and provide for control of the utilization of all services provided. In fiscal year 2010, HP completed 140 reviews. An estimated 14,700 charts were reviewed. KHPA also utilizes Hospital Utilization Reviews. KHPA contracts with Kansas Foundation for Medical Care (KFMC) which conducts reviews of a sample of fee-for-service inpatient hospital and ambulatory surgery center claims. Each claim requires a chart review. In fiscal year 2010, KFMC reviewed 14,173 charts.

- In response to the question as to why PSI was chosen over Maximus for the contractor for eligibility determination of Medicaid and HealthWave, a letter dated May 20, 2009, (Attachment 11) was provided. The selection of PSI was based on a comparison of the functionality and reporting capabilities of the software proposed, network security, support personnel, database design, training programs, methodology, time line, quality and overall solutions proposed by the various vendors. PSI proposed the most innovative and flexible customer service approach and excellent marketing and training ideas to promote outreach, quality and efficiency.

- In response to the question as to how many staff does PSI have, there are currently 152 employees.

- A flow chart (Attachment 12) was provided illustrating the process after an application is received.

- In response to the question whether Maximums was penalized for the backlog, the response indicated no liquidated damages were assessed against Maximus because they were not in default under their contract. The scope of the contract significantly changed since 2003; the number of applications and reviews received by the Clearinghouse doubled and in July 2006, the citizenship and identity verification requirements were implemented. While the contractor requested and received some additional resources to compensate for the additional workload, some of their requests were denied for lack of funding and when funding increases were authorized by the State, they were never sufficient to keep pace with the cost associated with the additional amount of work. Therefore compromises had to be reached regarding performance. PSI contract amounts for FY 2010 through FY 2015 were provided.

- In response to how many appeals has KHPA lost due to the increased time to process HealthWave applications, the following was provided:

- There has been only one HealthWave application processing case that has gone to appeal. It is currently in litigation. KHPA has tried to work with families whose applications have taken longer than 45 days to offset any costs they may have incurred during their wait.

Dr. Allison notified the Committee he had again contacted CMS concerning the question of Kansas' ability to comply with section 403 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. He indicated it is his understanding their answer is the same as was previously discussed and he will share any letter with the Committee that is received from CMS.

Chairperson Landwehr adjourned the meeting at 4:15 p.m.

Thursday, December 9
Morning Session

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

Randy Bowman, Director of Community Programs, Juvenile Justice Authority (JJA), reported in October 2009, Keys for Networking, Inc. was awarded a federal Children's Health Insurance Program Reauthorization Act (CHIPRA) Outreach Grant and approached JJA to collaboratively assist in the enrollment of uninsured Kansas JJA youth and families for either Medicaid or the Children's Health Insurance Program (CHIP). This is a joint collaboration to benefit the lives of at-risk youth and their families, with no fiscal impact to the agency (Attachment 13).

In December 2009, a memorandum of understanding regarding the CHIPRA grant, referred to as the No Place Like Home Grant, was signed between Keys for Networking, Inc. and the JJA. With the positive outcomes being achieved for youth and families, the referral population was expanded to Juvenile Intensive Supervised Probation youth and soon will be expanded again to youth and families accessing the Juvenile Intake and Assessment programs across the State of Kansas.

Jane Adams, Executive Director, Keys for Networking, delivered a presentation about assuring youth under the supervision of JJA secure services and resources to pay for them. The purpose of the partnership is to: 1) determine eligibility for Medicaid/Healthwave youth under the custody of JJA; and 2) help youth/family find services needed to comply with court orders and to reintegrate with family, school and community (Attachment 14).

Going forward, CMS has approved a program expansion. There were 837 families and 1,628 youth in the program the first year. A number of charts illustrating the demographics of the referred youth and their insurance status were presented. Seventy percent of the families contacted have reported the following issues: 1) 73 percent reported mental health needs; 2) 48 percent reported physical health needs; and 3) 35 percent report substance abuse of needs.

The process includes:

- Contact each family by phone day of referral;

- Assign peer mentor (experience with corrections);
- Interview for perceived needs, court-ordered services, current insurance, follow up to assure access;
- Locate application, move it forward;
- Complete application, compile supporting documents;
- Send completed application form to parents for approval and signature;
- Submit to KHPA; and
- Follow up/meetings with KHPA Liaison/Clearinghouse.

There are time issues related to insurance. State-issued medical card expires on the last day of the month if the youth returns home before the 15th or on the last day of the following month if the youth returns home after the 15th. Several charts illustrating time lines for insurance coverage and insurance lapses were reviewed. Card delays cause issues for youth and family including loss of freedom, loss of community resources, loss of school and academic services, loss of credits, loss of mental health/substance abuse treatment providers they know, and loss of family.

Problems families experience using the card include:

- Hard to find medical providers who accept the card and providers who offer needed services;
- Substance abuse treatment; and
- Dental.

Primary uses of the card include:

- Securing mental health services-therapy;
- Filling medications for ADHD, depression;
- Securing substance abuse evaluations and treatment;
- Connecting to dental care;
- Completing pre/post natal visits; and

- Transportation.

How we did it:

- Employ parents who share the experience of our clients;
- Discuss use of medical card/service options;
- Help families connect to the services;
- Teach families to secure quality services and monitor youth outcomes;
- Build technology to house records, autofill applications, self-help feature for 2011;
- State Agency Support.

The American Institute for Research reports that Keys informed/engaged parents are more likely to enroll/stay enrolled at the 0.05 significance level than parents who receive assistance only at their request.

A question was asked concerning the time line and dollar amount of the grant. The grant was for $400,000 plus for two years. It started October 2009 and will end in 2011 with the intent to apply again for another grant.

When reviewing the information on the turnaround time provided to the children in this program, Committee members raised concerns that children covered by state agency programs are being given preferential treatment over children not covered by state aid. This concern reflects back to the presentations by KHPA presented on December 8 on the overall backlog of over 45 days, in which it was indicated that there is no preferential treatment other than for pregnancies and medical emergencies.

There was a question concerning the number of staff added due to the grant and it was noted that six staff were added. If another grant is not provided, the six additional staff would be released and the services that have been successful with the grant would no longer be able to be provided.

Additional comments were made about the budget reductions that occurred and affected the ability of KHPA to address the backlog and the need to give KHPA time to meet its March goal of eliminating the backlog. It was acknowledged that better information needs to be provided to the Legislature about the potential ramifications of budget reductions being considered.

There was a question concerning why dental providers are not accepting the card, *i.e.,* is it related to the level of reimbursement or other issues. Ms. Adams did not have an explanation, but indicated they do try to assist the families in acquiring dental services.

There was a question concerning the speed of processing renewals. Ms. Langner indicated renewals are handled differently as they implemented an automatic two-month extension and applicants are notified of the two-month extension. She believes most of the backlog is new applications. Chairperson Landwehr requested Ms. Langner review and verify the numbers that were looked at yesterday, how many are renewals versus new applications. In addition to the breakout of new versus renewal applications, a breakout of the 200 percent and 250 percent of poverty was requested.

Cathy Harding, Executive Director, Kansas Association for the Medically Underserved (KAMU), presented a solution to a request made at the November Committee meeting. Following a presentation by Teresa Brooks, of Polsinelli Shughart PC, regarding all the pilots, demonstrations, and grants that are and will become available to states through the Patient Protection and Affordable Care Act, a question was raised on who in Kansas is coordinating all of these opportunities so Kansas receives its fair share of the grants available. KAMU offered to assist in this endeavor. Following is KAMU's plan to monitor the opportunities available through the Affordable Care Act (ACA) and to communicate with key agencies, associations and organizations in the state, with the goal of securing as many resources as possible to benefit the people of Kansas (Attachment 15).

KAMU plan to track opportunities in the ACA to benefit Kansans:

- Add one staff person at KAMU to devote approximately 0.5 FTE toward monitoring the opportunites of the ACE;

- Add a link to the KAMU website dedicated to ACA opportunities, and provide the website link to associations, organizations, and governmental entities involved in health care services; and

- Form an ACA Advisory Group to determine what entities should be actively contacted and encouraged to pursue identified opportunities.

She indicated that, currently, the KAMU budget allows for a staff member to devote a portion of his or her time to coordinate this effort, but this work will be possible only if current funding levels remain.

Betty Wright, Executive Director, Kansas Dental Board, presented comments on corporate dentistry in Kansas (Attachment 16). The Board consists of nine members: six dentists, two dental hygienists and one public member. The mission of the Dental Board is to protect the public through licensure and regulation of the dental profession.

The Board has been entrusted with enforcing the Dental Practices Act in order to protect the public. The Board has no voice or stand on the issue of Medicaid providers or reimbursements. In fact, there are three references to Medicaid in the Kansas Dental Practices Act (KDPA). These are:

- Allowing dentists to be employed by Federal Qualified Health Centers (FQHC) and indigent clinics who accept Medicaid;

- Hygienists with extended care permits may provide services to children who qualify for Medicaid; and

- Mobile dentistry regulations require the operator to notify parents that their treatment may affect their Medicaid benefits.

The remaining topic covered Kansas law regarding corporate dentistry. There are five provisions in the KDPA that limit corporate ownership.

- Dentists may not be employed by an unlicensed proprietor;

- Corporations may not practice dentistry;

- A dentist may not split fees with a non-dentist;

- Dentist(s) owners must be in the practice a majority of the time the office is operated; and

- Franchises are prohibited.

The following additional comments were provided on each point. Specific details of the law were included in the attachment.

- If the dentist works for a corporation, the corporation is considered to be practicing dentistry as an unlicensed proprietor. Unless a dentist is employed by another dentist or a professional dental corporation or by certain exceptions such as indigent health care clinics, FQHCs, or state institutions, the dentist is in violation pursuant to KSA 65-1424.

- Before enacting KSA 65-1425 against corporate dentistry, early case law described a public policy against corporations practicing medicine and dentistry. In *Winslow v. Board of Dental Examiners*, 115 Kan. 450 (1924) the Supreme Court said "[c]orporations may not be graduated from dental colleges, they have neither learning nor skill, and they may not be examined, registered or licensed as dentists. Therefore, the legislature does not permit the organization of a domestic corporation to practice dentistry." The Court said the prohibition was to protect the public. In the Winslow case, the dentist's license was revoked for being employed by a corporation —receiving a salary and commission for dental work on the corporation's clients.

- The division of dental fees is a violation. Some business models in which a corporation shares in the profits of a dentist may be considered as fee splitting with a corporation. Also the process of "bonuses" for staff when patients are converted to more profitable procedures can be viewed as a violation of the KDPA.

- In order to assure that the dentist owner is overseeing the operations of the office, and is accountable to the board and to the patients, all owners of a dental practice are to be present in the office a majority of the time the office is operating, except for a recent change in order to alleviate access to care issues in rural areas, there is an

exception to the majority presence rule (g), but most dentists must comply—refer to (d) of KSA 65-1435.

- The KDPA is clear that franchise dentistry, another form of corporate dentistry, is prohibited—pursuant to (e) of KSA 65-1435.

The purpose of these restrictions on the corporate practice of dentistry are to assure that the dentist is in control of the office itself, and is in control of the treatment decisions for the patients. The legislation was enacted to hold the dentist accountable for the direct care of the patient. Once the dentist becomes simply an employee, or absentee owner, the office focus tends to be on maximizing profits, rather than maximizing care for the patient. The Kansas law intentionally creates a dental care system that is a "cottage industry" where the dental home of the patient is owned and operated by the provider of care. The business model is intentionally restrictive, so that the dentist owner is accountable to the board. If corporations and other absentee owners are in charge, they tend to demand lower quality materials, higher patient volumes, and/or shorter patient treatment times so the employed dentists are placed in the position of a poorer standard of care. The board would not have authority over the root cause of the problem, but the practitioner who is subject to the pressure must uphold professional standards. Kansas laws and regulations are currently in the best interest of the public.

There was a question as to how many dentists currently have licenses in Kansas, and Ms. Wright indicated there are 1,427 dentists. The Committee requested information on how many hours per week are worked by inspectors and how often they inspect the dentists.

There was discussion concerning the status of an ongoing investigation into a potential violation of corporate dentistry in Kansas and concern about the length of time the investigation has taken from initial awareness of a potential violation around 2005 to the present time frame with no action taken and no consumer complaints. The Committee requested the following information be brought back in January: how many complaints have been filed by patients of the potential violator about substandard care; how many of the complaints were valid, and how serious were the complaints and should they have risen to the level of a dentist losing his license.

Brad Smoot addressed some of the questions relating to this investigation. He indicated each of the clinics is independent, owned independently, and each has a management services contract with a company known as FORBA, a provider of such management services. He believes each of those independently owned clinics complies with the laws of Kansas.

Kevin Robertson, Executive Director, Kansas Dental Association, presented information on Medicaid dentists and corporate ownership of dental practices (Attachment 17). Kansas Dental Association represents 1,250 dentists or about 77 percent of the state's licensed dentists. According to the Dental Provider Participation Analysis reports compiled by the Kansas Health Policy Authority, the number of Medicaid recipients receiving dental care has increased, by more than 11 percent from June 2008 to June 2009 and by about another 9 percent from June 2009 to June 2010.

About 600 dentists or 40 percent of the 1,430 practicing dentists in Kansas are enrolled Medicaid providers. Of those, around 350 or 25 percent of Kansas dentists are active Medicaid providers that have treated patients within the past year. These numbers include approximately 57 orthodontists, 31 endodontists, 34 periodontists and 10 other dental specialties that would have very little or no ability to provide care in a children's-only system. In 2009, these Medicaid

dentist providers treated 70 percent of the children enrolled in Medicaid, 20 years of age and under.

Delta Dental Plan of Kansas is by far the largest dental insurance company in Kansas with 850,000 insureds and a provider network that consists of 91 percent of all the dentists in the state. Most would agree that an employed Kansan with Delta Dental insurance has dental access, yet Delta reports that only about 50 percent of its dental insurance policyholders and their dependents see a dentist in a given year.

There have been and are numerous obstacles for dentist Medicaid providers, including a 10 percent reimbursement rate cut last year (since restored); discontinued funding of the Frail and Elderly, Pregnant Mothers and Developmentally Disabled HCBS waivers; an overall reimbursement rate of 56 percent of actual dental fees on procedures when dental office overhead averages 60.5 percent; no overall rate increases since 1999 while regular inflation has increased 31 percent in that time; the elimination of all Medicaid dental provider support has left many dentists without assistance; and no one is actively recruiting new provider dentists.

This past August, the KDA recruited 55-60 dental offices in a short two-week period to participate in an adult dental program at Medicaid rates prior to September 30. This was not Medicaid, but the dentist response shows that dentists are willing to provide care even at lower rates when called upon.

The KDA is very interested in improving Kansas Medicaid to make it a more workable model for dentists and patients to maximize the care available to Medicaid recipients. The KDA welcomes the opportunity to work with the legislature and KHPA on this. The KDA vision includes streamlining the provider contract and claims processing, adjusting provider rates to the same level as the state employee health plan, allowing more freedom for Medicaid patients to choose a dentist and developing a better case management that will work to reduce the Medicaid no-show rate of 35-40 percent versus 6 percent for other dental patients.

The KDA supports expansion of dental Medicaid to include adult Kansans. Currently, the dentists of Kansas fund, administer and support perhaps the only two programs for adult dental care in Kansas through the Donated Dental Services (DDS) program and the Kansas Mission of Mercy (KMOM) Dental Project. State funding for the DDS Program was cut by KHPA in 2009 after 13 years of support. Private grants and personal funding by dentists have been raised to continue the program through FY 2011. DDS' 350 dental providers complete approximately $500,000 in free dental care each year mostly to disabled and elderly patients. The administrative cost of this program is $70,000.

The annual KMOM Dental Project administered by the KDA's own Kansas Dental Charitable Foundation consistently provides about 1,800 patients with around $1 million in free dental care per year. KMOM has never received a government grant or tax-based support with the exception of local law enforcement or government facilities that from time to time are donated for the event. It costs approximately $60,000 annually to put on a KMOM Dental Project. In all, the nine KMOMs have provided care to 17,500 patients totaling $8.5 million. Nearly half of the dentists in Kansas have participated in at least one KMOM Dental Project. In all, it is estimated that the average dentist provides $33,000 in charity and reduced-fee care to patients every year. That comes to $46.3 million in free and reduced care annually given by Kansas dentists to the people of Kansas.

It is somewhat difficult to address the issue of corporate dentistry since there is not a specific proposal to discuss. As a philosophy, however, the KDA supports licensed dentists

owning, operating and managing dental practices. This promotes the public welfare and best ensures that the line of responsibility from the dentist to the patient is not broken. As such, the KDA does not support the corporate practice of dentistry. The type of payment mechanism or third party assistance does not affect the KDA's concerns regarding the corporate practice of dentistry.

The relationship of confidence between dentist and patients is essential to patient welfare and treatment success. The best interest of the patient should not be compromised as a result of a relationship or arrangements by a dentist working for an out-of-state corporation. Decisions regarding finances and profitability can create external pressures from owners on employee dentists that affect patient care. Such decisions should be made only by dentists licensed by the Kansas Dental Board and accountable to the Board. The KDA fears that dentists' professional responsibilities may be undermined if a dentist is answerable to a corporate board of directors or lay managers. Some organizations may encourage under-treatment of patients in order to maximize the "bottom line," while others may encourage over-treatment with more expensive, marginally necessary procedures. Although some potential owners would argue that they would never interfere with the clinical judgment of a dentist, the promise of bonuses, ownership and advancement to a new graduate dentist can be as harmful to patient care decisions as edicts and quotas.

The Committee determined it would be beneficial to have a roundtable discussion with dentists and others who would have an interest in the following topics:

- Do we need to look at our current statutes?
- Is corporate dentistry good or bad?
- How do we get more dentists involved with Medicaid patients?

The meeting was recessed for lunch at noon.

Afternoon Session

Chairperson Landwehr reconvened the meeting at 1:30 p.m.

Dan Murray introduced Lawless Barrientos, Public Affairs Director, Comfort Dental, who appeared on behalf of Comfort Dental, based out of Lakewood, Colorado, and was founded by Dr. Rick Kushner in 1977 (Attachment 18).

There are currently Comfort Dental practices in seven states: Colorado, Wyoming, Kentucky, New Mexico, Missouri, Ohio and Texas. It is critically important to note that Comfort Dental practices are privately owned and operated by dentists who are licensed in the states in which they practice. Comfort Dental practices epitomize the "family-friendly" concept.

Collectively, Comfort Dental dentists see 1,500,000 patients per year. The Comfort Dental franchise has over 78 private practices and 286 partner dentists. The mission is to

provide quality, affordable dental care to all economic classes. Comfort Dental improves access by having extended office hours and 24-hour emergency access. Regular business hours are generally Monday-Friday from 7:30 a.m. to 7:30 p.m. and Saturdays from 7:30 a.m. to 1:30 p.m. Pricing tends to be 40-60 percent lower than the average private practice dentist. The dentists make a point to go over dental prices and options with patients, with prices and dental procedures and care posted to the consumer. The average dental Medicaid provider is well below the national average in Kansas. Comfort Dental is one of the largest Medicaid providers in Colorado. On average, Comfort Dental Private Practice Dentists treat approximately 40 percent under-insured/uninsured, 20 percent Medicaid and CHIP patients.

Dr. Craig Bahr and Dr. Matt Draper live in Kansas, but have to drive over the state line to practice in Missouri. They would like to open up a Comfort Dental practice in Kansas. Further information from officials of the city of Colby, who reached out to Comfort Dental in hopes of attracting an affordable, Medicaid-focused dental practice to their rural community, will be provided at another time.

Mr. Barrientos stated as they have attempted to work with the Kansas Dental Board to establish a Comfort Dental practice, they were disappointed that their interpretation of current law prohibits such a practice. In short, they were told to "go the Legislature and change the law."

Comfort Dental does plan to attempt to change the law in the 2011 Legislative Session. There is an obvious need to attract more dentists to Kansas. There is an even greater need to attract dentists who are willing to take Medicaid patients. Comfort Dental feels strongly that local communities and most importantly the consumer would benefit greatly from a dental practice owned and operated by highly-trained licensed dentists which embrace transparency in their pricing and maintains extended weekday and weekend hours.

At a time when young dentists leave dental school with tremendous debt, limiting their options to own their own dental practice, a franchise ownership arrangement offers an attractive option for them that Comfort Dental believes would be welcomed by the dental community and the regulating agency. Comfort Dental wants to be part of the solution to the very real dental shortage issue in Kansas.

A map was provided (Attachment 19) which illustrates states which have Comfort Dental locations, states that permit dentist-owned franchises, and states that do not permit dentist-owned franchises. The map indicated Kansas was the only state that did not permit dentist-owned franchises. It also defined Corporate Dentistry as a company-owned-and-operated dental care facility. Franchise dentistry is the practice of dentistry under a trade name, the rights of which have been purchased from another dentist or dental practice.

There are about 18 dentists who currently live in Kansas and drive out of the state to have their practice, who are interested in opening a practice in Kansas.

Dr. Craig Barr addressed the Committee, speaking in favor of the Comfort Dental concept. He indicated the dentists leverage their time and share the expenses so it works out well for them. Expenses are reduced because of the purchasing power of the franchise and the total number of hours worked at the facility.

The Committee wanted to know in what cities the Comfort Dental franchises are located, which will be provided by Mr. Barrientos (Attachment 20).

In response to a question raised at the December 8 meeting, Ms. Langner provided the following list of KHPA contracts in process of negotiation for the period December 2010-January 2011 and addressed Committee questions:

- Kansas Foundation for Medical Care—External Quality Review Organization (EQRO) amendment will reduce the number of review tasks to only those that are required by regulation. Amendment is effective December 1, 2010, and will create anticipated all funds savings through calendar year 2014.

- Policy Studies, Inc. (PSI)—Clearinghouse amendment for enrollment in Title XIX and Title XXI programs will reinstate performance standards effective December 31, 2010. This amendment reinstates requirements resulting from the Governor's budget cuts issued on November 23, 2009. KHPA recognized that PSI would not be able to meet all of the performance expectations, performance standards, performance guarantees, industry standards, implied requirements, and other requirements for all areas of this contract as stated in the contract. This is a no-cost amendment.

- Medical Transportation Management—Non Emergency Medical Transportation amendment will extend the contract for one year from June 30, 2011, through June 30, 2012, and adjust the Per Member per Month (PMPM) rate for increased utilization. Cost of PMPM is currently being developed by KHPA staff.

- Public Consulting Group – This amendment will be for one year beginning February 1, 2011, and is for School District Medicaid matching and cost settlement for Special Education Services.

Chairperson Landwehr requested staff to briefly provide the Committee with an overview of what has been covered the past two meetings to assist in the development of items to be addressed and included in the Committee report.

Chairperson Landwehr then requested recommendations that the Committee would like to be included in the report.

Senator Schmidt made two recommendations for the report:

- The Kansas Health Policy Authority exclude from the Pharmacy Brand Name Limitation the current preferred drug list items. The name brand rebate Kansas currently receives on these items are larger than the savings on generic drugs.

- The Kansas Health Policy Authority cease signing or amending any contracts until the new administration is in place on January 10, 2010. The Committee understands that its actions cannot stop the process, but the Committee strongly wishes to register the members' discomfort with these actions.

There was much discussion concerning Senator Kelly's request that the Governor and Governor-Elect submit letters of support for the Early Innovator Grant Program and that the Kansas Insurance Department apply for the grant in a timely manner. There were some

concerns that if the state gets the grant, what would be the future potential expenses tied to it. The Governor and Governor-Elect would need to meet with Commissioner Praeger to review the grant and then determine whether they are comfortable with making the request for the grant.

It was agreed a letter be sent to the Legislative Coordinating Council recommending that consideration be given to sending a letter of support for the Early Innovator Grant. However, the Chair expedited the issue by having verbal communication with a member of the transition team, Kansas Insurance Commissioner and the Vice-Chair of the Committee. It was important to the transition team to not step over boundaries of one governor at a time. The transition team and the Insurance Commissioner would visit with the Governor. In addition, it should be noted that the Committee at the Roundtable held December 14, 2010 supported the application for the grant because an exchange could be helpful no matter what happens to the federal health care legislation.

It was concluded that Kathy Sparks, KLRD, would provide a summary report of the information discussed at the November and December meetings. A final vote on the report will be done via e-mail.

Chairperson Landwehr adjourned the meeting at 3:30 p.m.

Prepared by Debbie Bartuccio
Edited by Kathie Sparks

Approved by the Committee on:

January 13, 2011
(Date)

Kansas Health Policy Oversight
Attendance
December 8, 2010

Anne Marie Hughey	SKIL
Robin Clements	OCCCA, Youthville
[illegible] Meyer	Kansas Reporter
Nancy Zogleman	Polsinelli
Patrick Hurley	PSI
Stan [illegible]	TFI
Michelle [illegible]	Cap-Strategies
[illegible]	Kearney & Assoc.
Berend Koops	Hein Law Firm
Bob Williams	Ks Assoc Osteopathic Medicine
Barbara Belcher	Merck
Brad Smoot	BCBS
Katy Belot	SRS
Kerri Spielman	KACA
S. Therese Bangert	Sisters of Charity of Leav.
Chad Austin	KHA
Barb Conant	KDOA
[illegible]	LPA
Joseph Cullen	LPA
[illegible]	KFMC
[illegible]	LPA
[illegible]	Unicare
[illegible]	KMHC
[illegible]	KNG
[illegible] Williams	LPA
Jim McLean	KHF

Ks. Health Policy Oversight

Attendance
December 9, 2010

Bill Sneed	Polsinelli Law Firm
Rusty Bowman	KJJA
Jeff Butrick	KJJA
David Rowe	KUMC
Mary Ellen Conlee	KEYS
Katy Belot	SRS
Sandy Braden	Corbet, Braden & Assoc.
Steve Johnson	TFI Family Services
Michelle Butler	Capitol Strategies
Sara Pittman	KFMC
John Kiffmeyer	Ks. Chiropractic Assoc.
Dan Murray	Fed Consult
Lawless Barrientos	Comfort Dental
John Peterson	Ks Dental Assn
Nikki King	Health Care Access Clinic
Bill Wright	Ks Dental Board
Melissa Gratz	KDB
Cathy Harding	KAMU
John Bottenberg	Bottenberg & Assoc
Gary Robbins	Kansas Optometric Assn
Bernd Koops	Hein Law Firm

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KANSAS HEALTH POLICY AUTHORITY

December 8, 2010
Kansas Health Policy Authority Oversight Committee
Follow Up from November 4-5, 2010

What is the timeline for all pharmacy changes?
See Attached chart.

Senate Substitute for HB 2631 instructed KHPA to reduce the number of brand name drugs allowed from five to four, what might we save from reducing that limit to two?

The FY2011 budget included $12 million (all funds) savings associated with reducing the brand limit and implementing a tiered co-pay; the savings projected in the legislative budget bill was based on an increase in the generic dispensing rate (i.e. how often a generic medication is dispensed vs. a brand-name), rather than directly as a result of the policy changes themselves. KHPA is hesitant to project additional short-run savings (FY 2012-2013) that might result from a further reduction of brand name drugs allowed from four down to two.
It is our understanding that the savings proposed by the legislature was estimated by what could be saved if the generic dispensing rate for Kansas Medicaid was as high as that of neighboring Oklahoma Medicaid – 4.4% higher. Kansas and Oklahoma have a different set of pharmacy policies that contribute to the overall rate of generic dispensing. The brand limit utilized by Oklahoma Medicaid is two per calendar month, with only cancer, HIV, and oral contraceptives exempted. Since this year's budget already assumes Kansas will reach Oklahoma's generic dispensing rate, reducing the number of brand name prescriptions allowed in Kansas to the number allowed in Oklahoma is not anticipated to result in a *higher* generic dispensing rate than that experienced by Oklahoma.

In addition to a two brand limit, Oklahoma utilizes a tiered formulary system. Counter-intuitively, implementation of a tiered formulary in Kansas would result in a short-term increase in Medicaid expenditures. This is caused by a difference in federal co-pay requirements between tiered and non-tiered programs. For all providers, any patient co-pay amount is subtracted from the payment to the provider. For example, a $10.00 pharmacy claim with a $3.00 co-pay amount results in a $7.00 Medicaid payment to the pharmacy. Under federal requirements *for tiered formularies*, a $10.00 pharmacy claim is allowed a co-pay of no more than $0.60. The Medicaid payment to the pharmacy for a $10.00 claim in a tiered formulary is therefore $9.40, an increase of $2.40 over the payment in our current system. Over 70% of pharmacy claims would result in a higher cost-sharing requirement for Medicaid. We estimate this would result in an expenditure increase of $1M in the first fiscal year. The increase in expenditures could likely be recouped from the migration to lower-cost products cause by tiered formularies by inducing more prescriptions for $10 dollar generic drugs and fewer $50 dollar brand name drugs, but not within one fiscal year as this requires a change in physician prescribing patterns.

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www.khpa.ks.gov

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

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

JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT
DATE: 12-8-10
ATTACHMENT: 1

Do we send an explanation of benefits to Medicaid recipients and are notification for payment of services to consumers provided?

The Single State Medicaid Agency is required to have a method for verifying with recipients whether services billed by providers were received (42 CFR §455.20(a)).
KHPA currently sends Explanations Of Medical Benefits (EOMB) to 400 randomly selected fee-for-service recipients each month. In an informal survey of states conducted in January of 2009 through the National Association for Medicaid Program Integrity list serve, 14 of the states responded to the questions related to methodology used to issue EOMBs. Their responses indicated that they also were sending EOMBs to a sample of their recipient population.

Is there a way to measure the advantage providing consumers with notification that a service have been paid for on their behalf?

KHPA tracks the number of responses received as a result of the letters and any needed corrective action. In 2009, we received inquiries on 2.7% of the letters sent and 1.6% of the claims were questioned. From January through October 2010, we received inquiries on 1.4% of the letters sent and .07 % of the claims were questioned.
Further investigation of the questioned claims did not result in any finding.

What percentage of beneficiary's charts are reviewed for appropriate use?

KHPA conducts monthly chart evaluation as part of its utilization review processes.

1- *Surveillance and Utilization Review Subsystem (SURS)* - Federally mandated to monitor providers and consumer of Medicaid services:
SURS performs post-payment provider review, consumer reviews and data analysis to safeguard against unnecessary or inappropriate use of services and against excess payments, assess the quality of services and provide for control of the utilization of all services provided. In fiscal year 2010, HP completed 140 reviews. An estimated 14,700 charts were reviewed.
2- *Hospital Utilization Reviews* —KHPA contracts with Kansas Foundation for Medical Care (KFMC)
KFMC conducts reviews of a sample of fee for service inpatient hospital and ambulatory surgery center claims. Each claim requires a chart review. In fiscal year 2010, KFMC reviewed 14,173 charts.

Why did we go with PSI over Maximus?
See Attached, May 20, 2009 letter.

How many staff does PSI have?
PSI currently has 152 employees.

Provide flow chart for how an application is received.
See Attached Flow Chart.

Was Maximus penalized for the backlog?

No liquidated damages were assessed against MAXIMUS because they were not in default under their contract.

The scope of the contract significantly changed since 2003; the number of applications and reviews received by the Clearinghouse doubled and in July 2006, the citizenship and identity verification requirements were implemented. While the contractor requested and received some additional resources to compensate for the additional workload, some of their requests were denied for lack of funding and when funding increases were authorized by the State, they were never sufficient enough to keep pace with the cost associated with the additional amount of work. Therefore compromises had to be reached regarding performance.

PSI Contract amounts:

1st Year Contract Price (FY10)	$7,194,228
Amendment 1 reduction (FY10)	($884,735)
Total Price for FY10	$6,309,493.00
2nd Year Contract Price (FY11)	$9,720,282
Amendment 2 reduction (FY11)	($1,062,310)
Total Price for FY11	$8,657,972.00
3rd Year Contract Price (FY12)	$9,883,720.00
4th Year Contract Price (FY13)	$10,049,880.00
5th Year Contract Price (FY14)	$10,130,879.00
6th Year Contract Price (FY15)	$9,840,755.00

How many appeals has KHPA lost due to the increased time to process HealthWave applications?

There has only been one HealthWave application processing case that has gone to appeal. It is currently in litigation. KHPA has tried to work with families whose applications have taken longer than 45 days to offset any costs they may have incurred during their wait.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 235
Kansas City, Missouri 64106

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Division of Medicaid and Children's Health Operations

November 16, 2010

Barbara Langner, Ph.D.
Director of Medical Policy
Kansas Health Policy Authority
Landon State Office Building
900 SW Jackson, Room 900N
Topeka, Kansas 66612

Dear Dr. Langner:

Thank you for your November 24, 2009 letter concerning Kansas' ability to comply with section 403 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. Section 2103(f) of the Social Security Act (the Act), as amended by CHIPRA section 403, requires State Children's Health Insurance Programs (CHIP) to apply a number of Medicaid managed care provisions to CHIP health plans. The Centers for Medicare & Medicaid Services (CMS) issued a State Health Official (SHO) letter on August 31, 2009 to provide general guidance on the implementation of Section 403 of CHIPRA.

Children's Health Insurance Programs operating a managed care delivery system must comply with section 2103(f) of the Act with respect to all managed care contracts entered into or renewed as of July 1, 2009. Section 3(b) of CHIPRA provides that the Secretary of Health and Human Services may extend the date by which a State must implement any provision if the Secretary determines that State legislation is required in order for a State's CHIP plan to be in compliance with the provision. The August 31, 2009 SHO letter requested that States requiring legislation notify the CMS regional office as soon as possible.

Your November 24, 2009 letter explained that State legislation will be required in order for Kansas to meet the disenrollment requirement. Section 1932(a)(4) requires States to assure that individuals have the right to disenroll from a managed care entity. Children eligible under the child health plan must have the ability to receive CHIP health care benefits through alternate means. Kansas currently uses one managed care organization (MCO) to deliver care to CHIP eligibles residing in the western region of the State. In our discussions with your staff, we understand that there is a total membership of only about 2,000 children in this thirty county area which would not support a second MCO. Your letter indicated that Kansas intended to offer a State run, fee-for-service alternative in the western region and that State legislation would be necessary to accomplish this because current State law requires CHIP to be administered through a managed care delivery system.

The Kansas Health Policy Authority (KHPA) has notified CMS that it presented testimony explicitly identifying the requirements of CHIPRA Section 2103(f) on December 17, 2009 to the Joint Committee on Health Policy Oversight, February 3, 2010 to the Senate Ways and Means Committee, and on March 2, 2010 to the House Social Service Budget Committee. Despite these efforts, the State Legislature did not choose to introduce legislation to address this issue during its 2010 session.

I am sending this letter to reiterate the need for the State to make a good faith effort to comply with the CHIPRA Section 2103(f) requirements. I encourage KHPA to do this by continuing to pursue modification of State law during the 2011 legislative session. As you know, Section 3(d)(2) of CHIPRA provides that federal financial participation (FFP) shall not be denied to a State which makes a good faith effort to comply with the requirements prior to the issuance of any guidance or regulations implementing the provisions in question.

We encourage Kansas to continue monitoring this managed care entity's network adequacy considering CHIP enrollment, expected utilization of services and panel restrictions in areas where there are limited providers. We appreciate Kansas taking the necessary actions to promote access and choice within the plan.

In addition, I invite you to share with CMS any additional challenges that compliance with CHIPRA Section 2103(f) poses to Kansas. CMS would be interested to learn of any difficulties the State expects to encounter in complying with the managed care disenrollment requirements in rural and frontier areas. CMS is particularly concerned that abruptly changing the State's enrollment practices for these families may cause disruptions or gaps in health care coverage. We appreciate Kansas taking the necessary actions to minimize disruption of coverage for these families while waiting for enabling legislation.

If you have questions concerning this letter, please contact Michelle Opheim or Megan Buck, Division of Medicaid and Children's Health Operations at (816) 426-5925.

Sincerely,

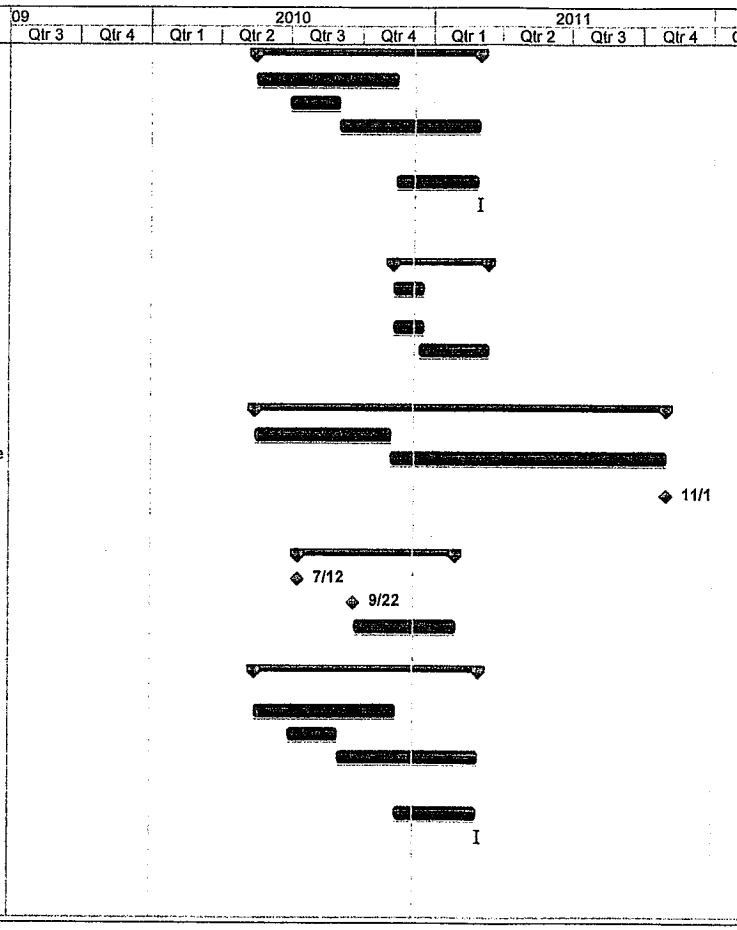
James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations

cc: Christiane Swartz

Kansas Health Policy Authority Pharmacy Projects

2010-2011

ID	Task Name	Start	Finish	Notes
1	**Reducing Over the Counter Drug Coverage**	**Mon 5/17/10**	**Thu 3/3/11**	**Related to 2011 budget**
2	Policy Research/Draft/Submission/KHPA Approval	Mon 5/17/10	Mon 11/15/10	
3	SPA Research/Draft/Submission	Wed 6/30/10	Wed 9/1/10	
4	SPA CMS Review/Approval	Thu 9/2/10	Wed 3/2/11	Estimated Finish Date. CMS has 90 days for SPA review but can stop the clock at any time. Questions received from CMS 12/02/2010.
5	HP Design/Development	Mon 11/15/10	Mon 2/28/11	
6	Implement	Thu 3/3/11	Thu 3/3/11	Design is not complete. The implementation date is not firm.
7				
8	**Specialty Pricing**	**Fri 11/12/10**	**Tue 3/15/11**	**Related to 2011 budget**
9	Policy Research/Draft/Submission/KHPA Approval	Fri 11/12/10	Mon 12/20/10	Research is not complete. Target implementation date has not been set.
10	SPA Research/Draft/Submission	Fri 11/12/10	Mon 12/20/10	
11	SPA CMS Review/Approval	Wed 12/15/10	Tue 3/15/11	Estimated Finish Date. CMS has 90 days for SPA review but can stop the clock at any time.
12				
13	**First Fill (15 day) Policy**	**Mon 5/17/10**	**Tue 11/1/11**	**Related to 2011 budget**
14	Policy Research/Draft/Submission/KHPA Approval	Mon 5/17/10	Mon 11/8/10	
15	HP Design/Development	Mon 11/8/10	Mon 10/31/11	Long development phase is due to the complexity of the editing to be built.
16	Implement	Tue 11/1/11	Tue 11/1/11	Design is not complete. The implementation date is not firm.
17				
18	**Drug Use Reviews**	**Mon 7/12/10**	**Mon 1/31/11**	**Related to 2011 budget**
19	Met with Eli Lilly	Mon 7/12/10	Mon 7/12/10	Discussed the possibility of funding the CMT project
20	Met with Eli Lilly	Wed 9/22/10	Wed 9/22/10	No funding available
21	Reviewing other funding options	Thu 9/23/10	Mon 1/31/11	Mailed solicitations to other manufacturers
22				
23	**4 Brand Policy (Single Source Prescription Limit Consolidation)**	**Mon 5/17/10**	**Thu 3/3/11**	**Related to 2011 budget**
24	Policy Research/Draft/Submission/KHPA Approval	Mon 5/17/10	Mon 11/15/10	
25	SPA Research/Draft/Submission	Wed 6/30/10	Wed 9/1/10	
26	SPA CMS Review/Approval	Thu 9/2/10	Wed 3/2/11	Estimated Finish Date. CMS has 90 days for SPA review but can stop the clock at any time. Questions received from CMS 12/02/2010.
27	HP Design/Development	Mon 11/15/10	Mon 2/28/11	
28	Implement	Thu 3/3/11	Thu 3/3/11	
29				
30				
31				



oject: Pharmacy Policies 2010-2011
Date: Tue 12/7/10

Task | Progress | Summary | External Tasks | Deadline
Split | Milestone | Project Summary | External Milestone

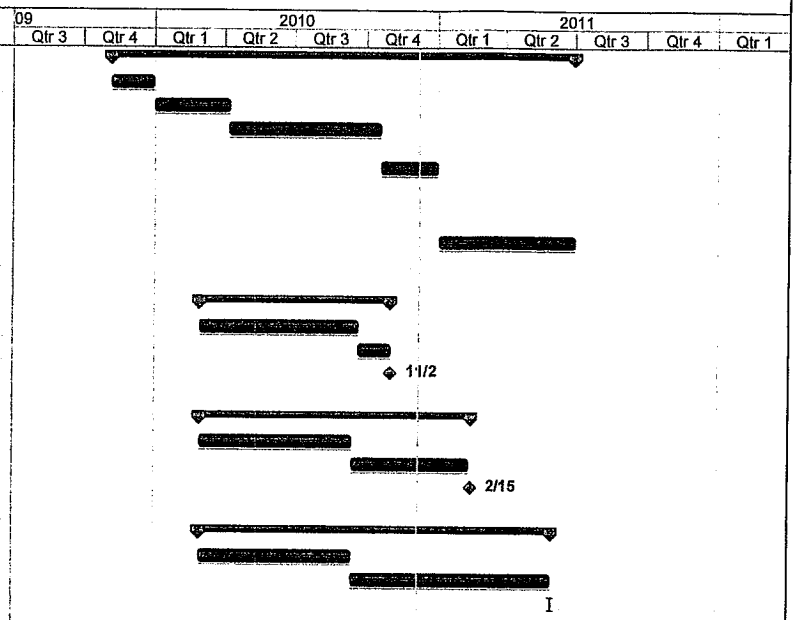
Revised 12-3-10

JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT
DATE: 12-9-10
ATTACHMENT: 3

Kansas Health Policy Authority Pharmacy Projects

2010-2011

ID	Task Name	Start	Finish	Notes
32	**Enhanced Prior Authorization (PA)**	**Fri 11/6/09**	**Thu 6/30/11**	**Related to 2011 budget**
33	RFI: Write/Post/Receive Responses/Evaluate	Fri 11/6/09	Wed 12/30/09	
34	APD: Write/Submit/Receive CMS Approval	Fri 1/1/10	Wed 4/7/10	
35	RFP: Write/Post/Receive Responses/Evaluate/Select Vendor/Draft Contract	Wed 4/7/10	Tue 10/19/10	
36	Contract CMS Review/Approval	Wed 10/20/10	Fri 12/31/10	Estimated Finish Date. CMS approval has been delayed due to CMS staff reductions which resulted in this contract being outsourced to a different CMS regional office.
37	Implement Pharmacy Enhanced PA	Mon 1/3/11	Thu 6/30/11	Vendor indicates Pharmacy Enhanced PA will be implemented 5-6 months after contract approval.
38				
39	**Dose Optimization for Long-Acting Opioids**	**Mon 3/1/10**	**Tue 11/2/10**	**Related to Legislative Inquiry**
40	Policy Research/Draft/Submission/KHPA Approval	Mon 3/1/10	Tue 9/21/10	
41	HP Design/Development	Tue 9/21/10	Mon 11/1/10	
42	Implement	Tue 11/2/10	Tue 11/2/10	
43				
44	**Limits for Long-Acting Opioids**	**Mon 3/1/10**	**Tue 2/15/11**	**Related to Legislative Inquiry**
45	Policy Research/Draft/Submission/KHPA Approval	Mon 3/1/10	Mon 9/13/10	
46	HP Design/Development	Tue 9/14/10	Fri 2/11/11	
47	Implement	Tue 2/15/11	Tue 2/15/11	
48				
49	**Limits for Short-Acting Opioids**	**Mon 3/1/10**	**Wed 6/1/11**	**Related to Legislative Inquiry**
50	Policy Research/Draft/Submission/KHPA Approval	Mon 3/1/10	Mon 9/13/10	
51	HP Design/Development	Tue 9/14/10	Tue 5/31/11	
52	Implement	Wed 6/1/11	Wed 6/1/11	Design is not complete. The implementation date is not firm.



oject: Pharmacy Policies 2010-2011
ate: Tue 12/7/10

Task — Progress — Summary — External Tasks — Deadline

Split — Milestone — Project Summary — External Milestone

Revised 12-3-10

Table of Contents

Kansas Insurance Department

Presentation to the Health Policy Oversight Committee

December 8, 2010

Purpose of Meeting

- Education
- Consumer Outreach
- Kansas-based solutions for Kansans
- Questions

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Kansas Statistics

- Kansas Population: 2.8 million (US Census Bureau, 2008)
  - U.S. population: 307 million (in 2009)
- Approximately 50 million people in the U.S. do not have health coverage (16.2% of the population).
- In Kansas, the number is approximately 340,000 (12.5% of the state population).

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JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT
DATE: 12-8-10
ATTACHMENT: 5

Introduction

Health Insurance Reform Overview

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Kansas Statistics

- In Kansas, health insurance breaks down the following way:
  - Nearly 88% of Kansans are insured (U.S. Census Bureau)
    - Nationally, more than 83% are insured
  - Of all Kansans, 13.8% have Medicare (Nationally, the average is 14.1% – Kaiser Family Foundation)

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Introduction

Health Insurance Reform Overview

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Questions?

Kansas Statistics

- In Kansas, health insurance coverage breaks down this way:
  - Ages 19 – 64 (2007-2008):
    - 65.8% of Kansans have employer-based coverage (Nationally, 63%)
    - 8.0% have individual coverage
    - 5.7% have Medicaid
    - 4.6% have other public insurance (Tri-Care, etc.)
    - 16% are uninsured

Sources: Averages from Kansas Health Institute, Kaiser Family Foundation

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Health Care Reform Enacted

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act of 2010 (H.R. 3590)

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Health Insurance Reform Overview

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Health Care Reform Enacted

On March 30, 2010, President Obama signed the Reconciliation Act of 2010 (H.R. 4872)

- This legislation amends the Patient Protection Act to:
  - Increase subsidies for low-income persons and penalties on employers
  - Phase-out the "doughnut hole" in Medicare Prescription Drug coverage
  - Modify tax provisions

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Health Insurance Reform Overview

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Questions?

Key Reforms – Early Implementation

- **High Risk Pool Grants** ($5 billion – 2010-2013)
  - Kansas received $36 million
- For individuals who currently do not have coverage and have a pre-existing condition
- Operational as of July 29. Coverage began Sept. 1. Separate from existing KS pool – new pool has only federal dollars, different cost to consumers. Continual enrollment.
- Currently 121 enrollees.

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Key Reforms – Early Implementation

- Health Plan Reforms (as of September 23, 2010)
  - No lifetime limits; First-dollar coverage for preventive services
  - No rescissions; Appeals process
  - Dependent coverage up to 26 years of age
  - No Pre-existing Condition Exclusions for Children

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Key Reforms – Early Implementation

- Grants for:
  - Consumer Assistance - grants to states for education and outreach
  - Rate Review
  - Exchange Planning
- Early Retiree Reinsurance Program
- Medical Loss Ratio -Rebates program beginning Jan. 1, 2011

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Key Reforms – 2014 Implementation

- Market Reforms:
  - Guarantee Issue and no Pre-existing Condition Exclusions in all markets
  - Rating Reforms limiting factors to age (3:1), geography, tobacco use and family composition
  - No annual limits

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Health Insurance Reform Overview

Exchanges

Questions?

Small Business Tax Credit

- Businesses with 25 or fewer employees.
- Average wages less than $50,000.
- Contribute at least 50% of premium.
- Phases out as size and wages of business increase.
- 2010-2013: Up to 35% of total employer contribution.
- 2014 and later: Up to 50% of contribution.

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Key Reforms – 2014 Implementation

- **State-Based Exchanges** for Individual and Small Group markets (fewer than 50 employees) that will provide standardized information on insurance choices and help consumers enroll in plans

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2014 Key Reforms (continued)

- **Individual Mandate** to ensure consumers do not wait until they are sick to seek coverage.
  - **Penalties for no coverage (whichever is greater):**
    - 2014 - $95 or 1% of household income.
    - 2015 - $325 or 2% of household income.
    - 2016 - $695 or 2.5% of household income.
    - Annual increases after 2016.

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Health Insurance Reform Overview

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Questions?

Large Employer Responsibility (50 or more FTEs)

- If employer **fails** to offer minimum coverage and one of its employees receives a subsidy through the Exchange, the employer will be subject to a penalty of $2,000 per employee.

- If an employer offers coverage but an employee receives a subsidy through the Exchange, the employer will be subject to a penalty of $3,000 per employee receiving a subsidy.

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Health Insurance Reform Overview

Exchanges

Questions?

KID and NAIC Working Groups

- Kansas Insurance Department Health Reform Working Group
  - Grant applications
  - Rate and form filing review
  - High risk pool
  - Consumer Ombudsman work
  - Exchange Planning/Coordination
  - Data collection
  - IT architecture

- **NAIC working groups (14 total),** including standardized definitions and uniform explanation of coverage.

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Introduction

Health Insurance Reform Overview

Exchanges

Questions?

KID Response Initiatives

- **Regular updates on implementation – consumer/business information posted-**

  - www.ksinsurance.org – special section on health reform with links to other sites

  - www.healthcare.gov - national web portal

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Health Insurance Reform Overview

Exchanges

Questions?

Kansas Insurance Department goal in federal health reform:

Work for the best possible outcomes

for Kansas consumers,

Kansas agents

and Kansas companies

by keeping reforms at the state level.

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Health Insurance Reform Overview

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Health Insurance Reform Overview

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Questions?

Statutory Timelines

- **Each state shall establish an American Health Benefit Exchange by January 1, 2014.**
  - Includes individual market and small group market Exchanges – these may be combined.
- **Small Group defined as 1-100 employees:**
  - State may elect to define as 1-50 until January 1, 2016.
  - State may elect to combine individual and small group markets.

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Introduction

Health Insurance Reform Overview

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Statutory Timelines

The Secretary of HHS must certify by January 1, 2013, that a state will be able to operate a qualified Exchange.

If a state does not, the federal government will operate it.

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Health Insurance Reform Overview

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Questions?

Federal Exchange Grants

•**Initial Planning Grants (Awarded Oct. 2010):**
$1 million to 48 states + District of Columbia.
-For research and planning:
•Market analysis
•Development of governance and operational framework
•IT assessment
•Stakeholder outreach
•Staffing
•Funding Requirements

•**Establishment Grants:**
•Details to be announced in Spring 2011.

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Health Insurance Reform Overview

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Exchanges

•The Exchange must be operated by a governmental agency or nonprofit entity established by a state.

•Legislature must enact laws for creation and implementation of Exchange.

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Health Insurance Reform Overview

Exchanges

Questions?

Key Decision Points

- ☐ Governance
- ☐ Additional Functions of the Exchange
- ☐ Additional Information for Consumers
- ☐ Regulation of the Outside Market
- ☐ Mandated Benefits
- ☐ Funding of Operations
- ☐ Role of Agents

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Introduction

Health Insurance Reform Overview

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Questions?

Role of Agents

- **States may allow agents and brokers to:**
  - Assist individuals and employers to enroll in qualified health plans in the Exchange.
  - Assist individuals in applying for premium tax credits and cost sharing reductions for plans in the Exchange.
- **States will establish compensation structure for agents and brokers.**

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Health Insurance Reform Overview

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Questions?

Role of State Agencies

- **Department of Insurance:**
  - Licensure
  - Certification
  - Market conduct
  - Enforcement
- **Medicaid and CHIP (Children's Health Insurance Program):**
  - Medicaid & CHIP eligibility determinations and enrollment

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Health Insurance Reform Overview

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Questions?

Individual & Small Group Exchanges

- Individuals may enroll in any qualified health plan offered in state Exchange.
- Employees have choice of carrier:
  - Employer may choose coverage level.
  - Employees choose from carriers offering at that level.
  - Employees individually rated (limited to four allowed rating factors).

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Questions?

Levels of Coverage

- **Bronze** – covers 60% of actuarial value of benefits.
- **Silver** – covers 70% of actuarial value of benefits.
- **Gold** – covers 80% of actuarial value of benefits.
- **Platinum** – covers 90% of actuarial value of benefits.
- **Catastrophic** – high-deductible plan for young (under age 30) and those exempt from individual mandate.

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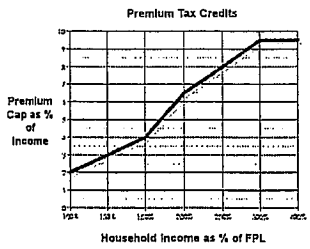
Questions?

Premium Tax Credits



- Available from 100% - 400% FPL.
- Covers the difference between premium for the second-lowest-cost Silver plan and a percentage of income.
- Advanced to insurer.

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Introduction

Health Insurance Reform Overview

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Questions?

Exchange Functions

At a minimum, an Exchange must:

- Operate a toll-free hotline for consumer assistance.
- Maintain an Internet website with comparative information about available qualified plans.
- The Exchange will certify qualified plans to be made available to individuals or employers. (dental plans can be included)

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Introduction

Health Insurance Reform Overview

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Questions?

Exchange Functions

At a minimum, an Exchange must:

- Inform individuals of eligibility for Medicaid, and CHIP and enroll them in such programs.
- Make available a calculator to determine the actual cost of coverage after application of premium tax credits and cost sharing reductions.

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Introduction

Health Insurance Reform Overview

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Questions?

Exchange Functions

At a minimum, an Exchange must:

- Grant a certification attesting that the individual is not subject to the coverage mandate because:
  - there is no affordable health plan available, or
  - the individual is exempt from the mandate
- Transfer to the U.S. Treasury Department a list of exempt individuals and employees eligible for premium tax credit

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Introduction

Health Insurance Reform Overview

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Questions?

Exchange Functions

At a minimum, an Exchange must:

- Establish a Navigator program
  - Exchange will award grants to entities such as: trade/industry groups, professional associations, farming organizations, consumer nonprofit groups, and chambers of commerce who will educate consumers and assist with enrollment in qualified health plans.

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Introduction

Health Insurance Reform Overview

Exchanges

Questions?

Plans Available in Exchange

- Qualified Health Plans must:
  - Be offered by a licensed insurance company.
  - Insure a sufficient choice of medical providers.
  - Provide information to the public regarding the quality of the plan.
  - Provide Essential Benefits as defined by HHS.

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Introduction

Health Insurance Reform Overview

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Questions?

Plans Available in Exchange

- Qualified Health Plans must:
  - Agree to offer at least one Silver and one Gold plan.
  - Agree to charge same price in and out of Exchange.
  - Utilize standardized format for presenting plan options.

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Introduction

Health Insurance Reform Overview

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Questions?

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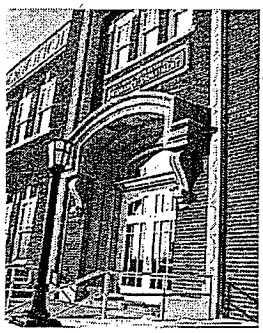
Kansas Insurance Department



420 SW 9th St.
Topeka, KS 66612

www.ksinsurance.org
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Phone:
785-296-3071
Consumer Assistance:
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785-296-7805

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Kansas Insurance Department
Kansas consumer education activities regarding the Affordable Care Act
March 2010 - November 2010

97 Kansas journalist media interviews (just Kansas - probably 3 times that many nationally)

43 Fulfilled speaker requests on health reform topics

6 KID-written articles in Kansas magazine

2 Monthly statewide Commissioner's Corner columns

2 News releases on health reform topics

3 Consumer Alert news releases on health reform topics

3 KID Insurance Quarterly electronic magazine articles on health reform topics

900-1,000 (est.) Consumer Assistance Division public calls for health care reform assistance/understanding

17 KID booth exhibits with information on health reform

10 days of State Fair presence with specific health reform pamphlets

2 Informational meetings on health care reform
Hays, KS - November 10, 2010
Overland Park, KS - November 23, 2010

www.ksinsurance.org
Special section on website - up since April - updated regularly

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

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

7-2

Coordinating health & health care for a thriving Kansas

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KANSAS HEALTH POLICY AUTHORITY

December 8, 2010

For more information, contact Peter Hancock
Public Information Officer
785/296-5603
Peter.Hancock@khpa.ks.gov

KHPA Awards Recovery Audit Contract to HealthDataInsights

Project Aims to Improve Accuracy and Generate Savings for Kansas

TOPEKA – The Kansas Health Policy Authority expects to generate several million dollars for the state general fund over the next three fiscal years through a contract that involves recovering past overpayments in the Kansas Medicaid program and the State Employee Health Benefits Program.

After a competitive bid process that included proposals from two national firms, KHPA has awarded a three-year contract for Recovery Audit Contract (RAC) services to HealthDataInsights (HDI).

The project, which is required by the federal Affordable Care Act as well as a proviso in the FY 2011 state budget, will involve reviewing claims paid through Medicaid and the State Employee Health Benefits Plan over the last several years, identifying instances of potential errors and overpayments, and then recovering those funds and returning them to the appropriate state or federal accounts.

HDI's proposal anticipates recovering a minimum of $16.08 million, all funds, during FY 2011-2013, including $5.3 million in State General Fund money. Since the federal government pays a portion of all Medicaid costs, a proportionate share of any Medicaid monies recovered through the RAC program must be returned to the federal government.

"We believe this contract will generate at least this amount in actual recoveries because of the way we structured our Request for Proposals," said KHPA Executive Director Andy Allison. "To make sure the bidders were competing on a level playing field, we required them to guarantee at least 90 percent of what they projected they could generate. So if a firm says they can produce $1 million, we have a guaranty of at least $900,000. These guarantees were designed to add legitimacy to the bids, but it may also have led to conservative projections of the amount of recoveries the state will receive. Now that the contract has been awarded, we'll manage the process to make sure the state is recovering all that it can and should."

(more)

JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT
DATE: 12-8-10
ATTACHMENT: 8

KHPA: Recovery Audit Contract – 2

HDI has over 25 years of experience in the health care claims integrity field. The company is headquartered in Las Vegas, Nevada, with additional facilities in California and Florida. HDI is currently the Recovery Audit Contractor for Medicare Region D, covering 17 states (including Kansas) and three U.S. territories. It also performs similar services for a number of private health insurance plans. From 2005 through 2010 it served as the Medicaid Payment Error Rate Measurement (PERM) contractor.

Under the federal Affordable Care Act, states are required to engage in RAC services in their Medicaid programs, beginning no later than April 2011. In addition, Kansas lawmakers included a proviso in the FY 2011 budget requiring KHPA to contract out for RAC services for both the Medicaid and State Employee Health Benefits Plan.

The proviso calls for reviewing claims paid for Medicaid-related services administered by KHPA; the Department of Social and Rehabilitation Services; the Department on Aging; the Juvenile Justice Authority; and the Department of Health and Environment.

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KANSAS HEALTH POLICY AUTHORITY

JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT
DATE: 12-8-10
ATTACHMENT: 9

Current KHPA RFPs

RFP Name	Anticipated Contract Award Date	Anticipated Award Cost
Recovery Audit Contractor	Awarded December 7, 2010	Contingency Fees on Recoveries
State Medicaid HIT Plan Development	January 5, 2011	Competitive Bid
Automated Prior Authorization	After January 1, 2011 (delayed by CMS review)	Competitive Bid
Health Reform Options	No sooner than January 14, 2011	Competitive Bid
Kansas Medical Eligibility Determination	May 2011	Competitive Bid

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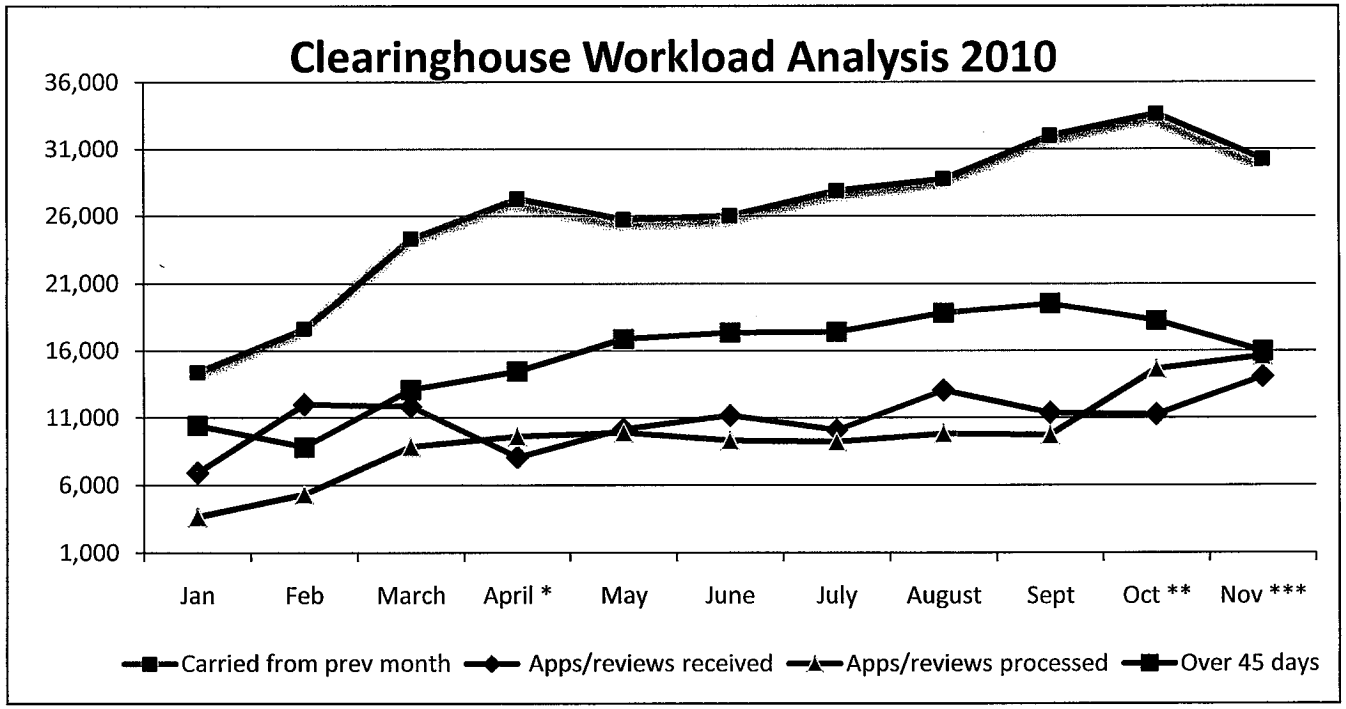
www.khpa.ks.gov

dicaid and HealthWave:
one: 785-296-3981
Fax: 785-296-4813

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

State Self Insurance Fund:
Phone: 785-296-2364
Fax: 785-296-6995



Please note:numbers have slighly changed as compared to the numbers on last month report. A reporting error was corrected during the month of Nov.

	Jan	Feb	March	April *	May	June	July	August	Sept	Oct **	Nov ***	Dec	**Totals**
Carried from prev month	14,390	17,649	24,302	27,284	25,741	26,009	27,876	28,759	31,987	33,641	30,224	28,666	
Apps/reviews received	6,910	11,975	11,823	8,048	10,145	11,157	10,068	13,024	11,340	11,226	14,057		**119,773**
Apps/reviews processed	3,651	5,322	8,841	9,591	9,877	9,290	9,185	9,796	9,686	14,643	15,615		**105,497**
Over 45 days	10,401	8,801	13,086	14,477	16,875	17,352	17,403	18,839	19,551	18,261	15,960		

* Numbers reflect Impact of the implemention 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

*** Total receipts increased by 2,831 during Nov. Applications received increased by 3,637 and reviews decreased by 806

Note: production went up by 972 since last month. Since staff augmentation, it has increased by about 5,800/month.

12/3/2010

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KANSAS HEALTH POLICY AUTHORITY

May 20, 2009

The Procurement Negotiating Committee for RFP/Contract #11821
Darin Bodenhamer, KHPA designee
Teresa Graber, Secretary of Administration designee
Thurston Smith, Division of Purchases designee

Dear PNC members:

Recommendation: The Kansas Health Policy Authority (KHPA) recommends that a contract be awarded to Policy Studies, Inc. (PSI) and Electronic Data Systems, an HP Company (EDS) to provide eligibility determination support services for AFDC-related Medicaid programs and be responsible for eligibility determinations and processing for SCHIP and Marketing Services, in accordance with the provisions of Request for Proposal (RFP) #11821.

In accordance with Section 4 all products and services proposed in response to this RFP were evaluated for their impact over the term of the awarded contract and for their positive contribution to KHPA staff effectiveness and productivity. As a result of our review and evaluation of the proposals received in response to RFP #11821 as well as the evaluations of the vendors' products at vendor demonstrations, KHPA has determined the proposal submitted by PSI/EDS best meets the state's needs for support services for AFDC-related Medicaid programs and responsibility for eligibility determinations and processing for SCHIP and Marketing Services.

Our recommendation is based on a comparison of the functionality and reporting capabilities of the software proposed, network security, support personnel, database design, training programs, methodology, timeline, quality and overall solutions proposed by the various vendors.

Background: Of the original four bids received it was determined the proposals submitted by ACS, MAXIMUS and PSI/EDS warranted further consideration and these three firms were invited to make on-site presentations of their software to KHPA staff.

ACS, MAXIMUS and PSI/EDS all have experience in working with Medicaid and SCHIP populations. MAXIMUS is the current HealthWave Clearinghouse vendor who provides support services for AFDC-related Medicaid programs and is responsible for eligibility determinations and processing for SCHIP. MAXIMUS and EDS have existing working relationships with Kansas. The three vendor responses to RFP Section 4.5 Automated Systems met KHPA's requirements and needs. ACS presented the most technologically advanced response with their automated tracking and support system, ConneXion. PSI/EDS proposed the most innovative and flexible customer service approach and excellent marketing and training ideas to promote outreach, quality and efficiency. All three proposals met the requirements of this project.

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Phone: 785-296-3981
Fax: 785-296-4813

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

State Self Insurance Fund:

Revised offers: After the vendor conferences, each vendor was asked to submit revised offers. The revised offers were received the week of April 30, 2009. The evaluation team met to review and discuss the revised offers along with the technical and original cost proposals, plus all follow-up questions and answers. The following table provides a summary of the team's evaluation of the three bidders:

Issue	Strengths		Concerns/Risks	Conclusion
Cost (Contract term)	Vendor	Cost (6 years)	Even though KHPA appreciated ACS's proposed case tracking and support system the cost of their proposal removed them from the competitive range for further consideration.	PSI/EDS are the lowest bidders for the six (6) year contract period.
	ACS	$73,067,922.00		
	MAXIMUS	$62,561,547.50		
	PSI	$56,673,743.56		
Response format as required by the RFP	Each vendor provided a comprehensive response.			Draw
Adequacy and completeness of the proposal	In the initial responses MAXIMUS and PSI provided some detail of how they proposed to meet the RFP requirements administratively and technologically. The evaluation team did submit clarification questions to each vendor to obtain more detailed information about the services and products proposed.			Draw
Compliance with RFP requirements	Both MAXIMUS and PSI complied with a majority of the RFP requirements.		MAXIMUS and PSI both indicated "Exceptions" with their initial response to KHPA's RFP. However, both MAXIMUS and PSI have agreed to comply with all RFP requirements per e-mails received on May 14, 2009. Both MAXIMUS and PSI initially proposed a segmented approach to the eligibility determination process. However, both vendors have proposed a more customer focused approach within their Revised Offers received April 30, 2009.	Draw

Issue	Strengths	Concerns/Risks	Conclusion
Experience in providing like services	MAXIMUS has experience with the Kansas Medicaid and SCHIP populations. Since MAXIMUS has the existing operation, implementation should follow with ease. PSI currently provides similar CHIP services in Tennessee and Georgia thus, has experience in processing and determining SCHIP eligibility. Additionally, PSI is partnering with EDS who maintains the existing MMIS operation and, has experience and a working knowledge of Kansas Medicaid and SCHIP beneficiaries.		Draw
Qualified/ Experienced staff	MAXIMUS proposed qualified, experienced staff in their respective areas of expertise with the exception of the Quality Assurance and Training Manager. PSI/EDS proposed qualified, experienced staff in their respective areas of expertise.	The individual proposed by MAXIMUS as the Quality Assurance and Training Manager who does not appear to have any experience or education in either of these areas. This is of concern to KHPA due to the sensitivity and importance of quality and training to ensure a successful project.	PSI/EDS
Methodology to accomplish tasks	MAXIMUS and PSI provided a detailed description of implementation and timelines. MAXIMUS proposes enhancements to MaxE2, a strong stable management and a reinvigorated Quality Assurance Program. PSI proposes an "effective, collaborative and transparent to stakeholders" implementation. Both vendors propose adequate methodologies to accomplish RFP tasks.	PSI - There is a 6 month implementation timeframe which will require both the State and the vendor to dedicate sufficient staff and hours to complete a successful implementation project. MAXIMUS - minimal staff training proposed and project management team lacked detail of qualifications and ability.	PSI/EDS

It is our recommendation based upon the review of all the information and materials submitted that the PNC make a conditional award to PSI/EDS, pursuant to the terms of the RFP, questions and answers and the Non-Specialization Model Revised Offer.

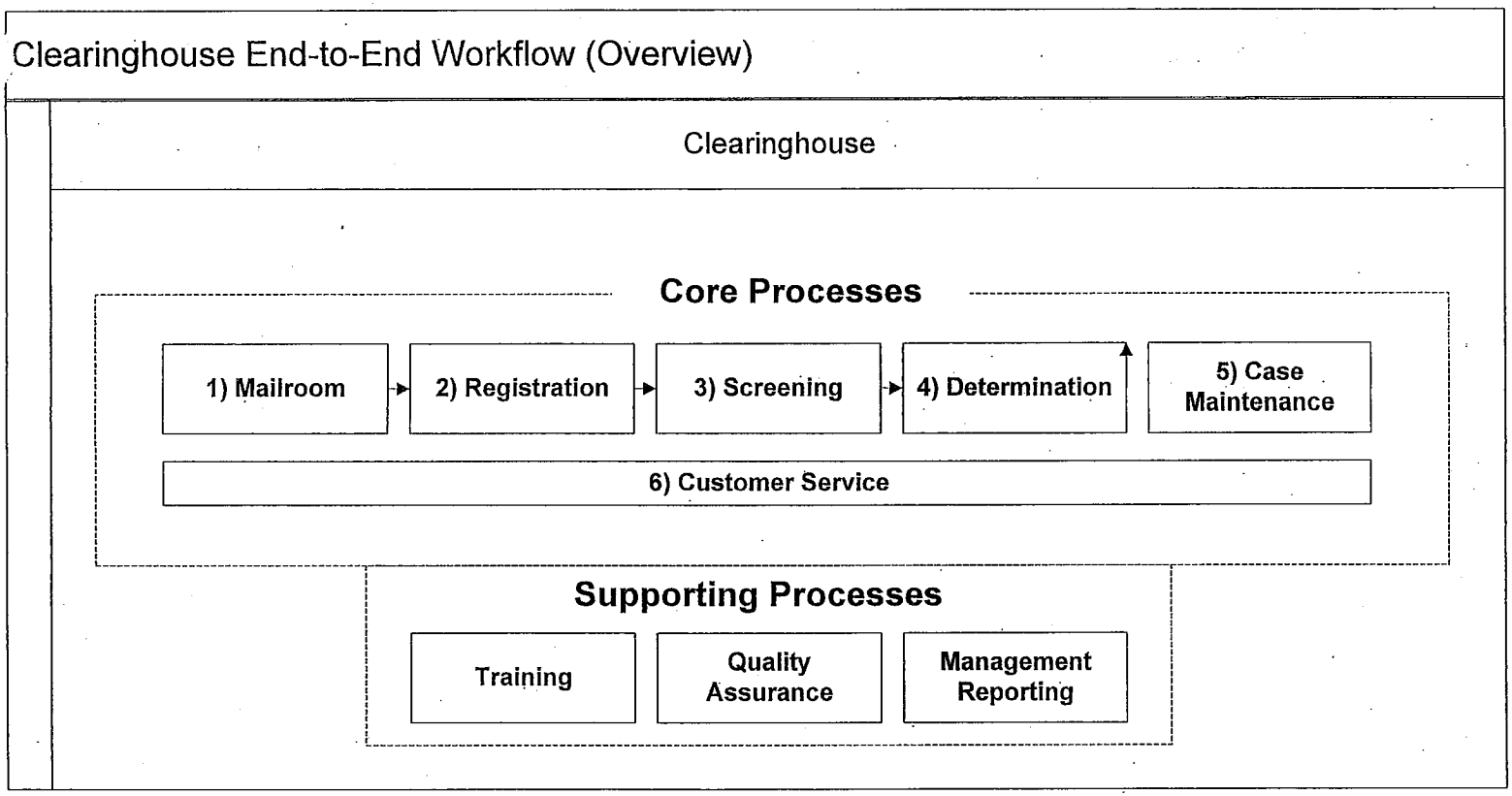
We have included a copy of our proposed contract document for your information and review.

Very truly yours,

for Marcia J. Nielsen, PhD, MPH
Executive Director,
Kansas Health Policy Authority

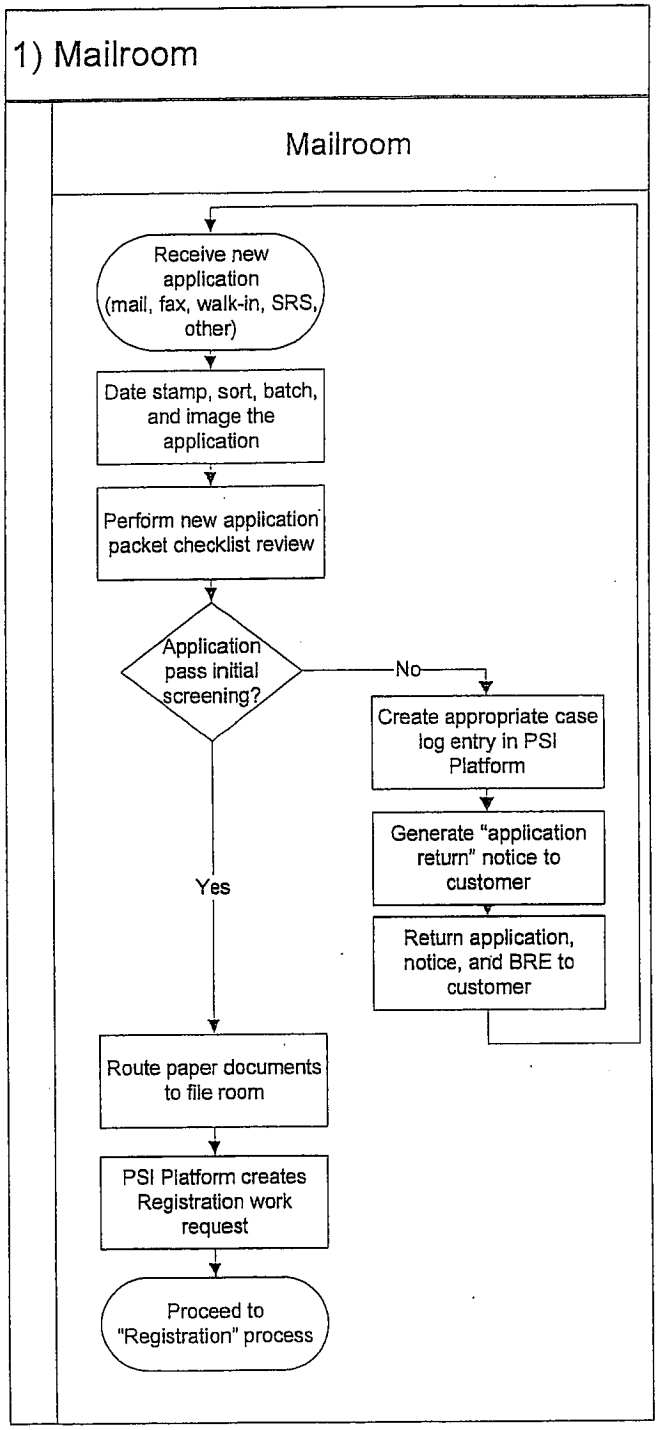
11-3

Kansas HealthWave Clearinghouse High Level Workflow

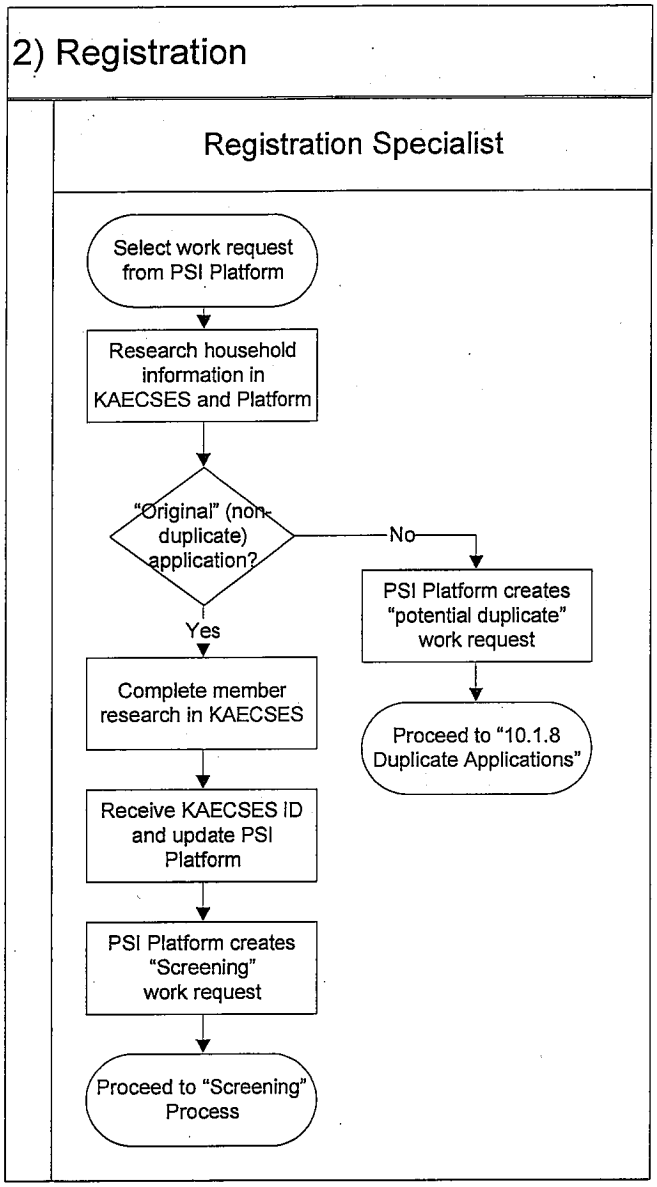


Joint Committee on Health Policy Oversight
12-8-10
Attachment 12

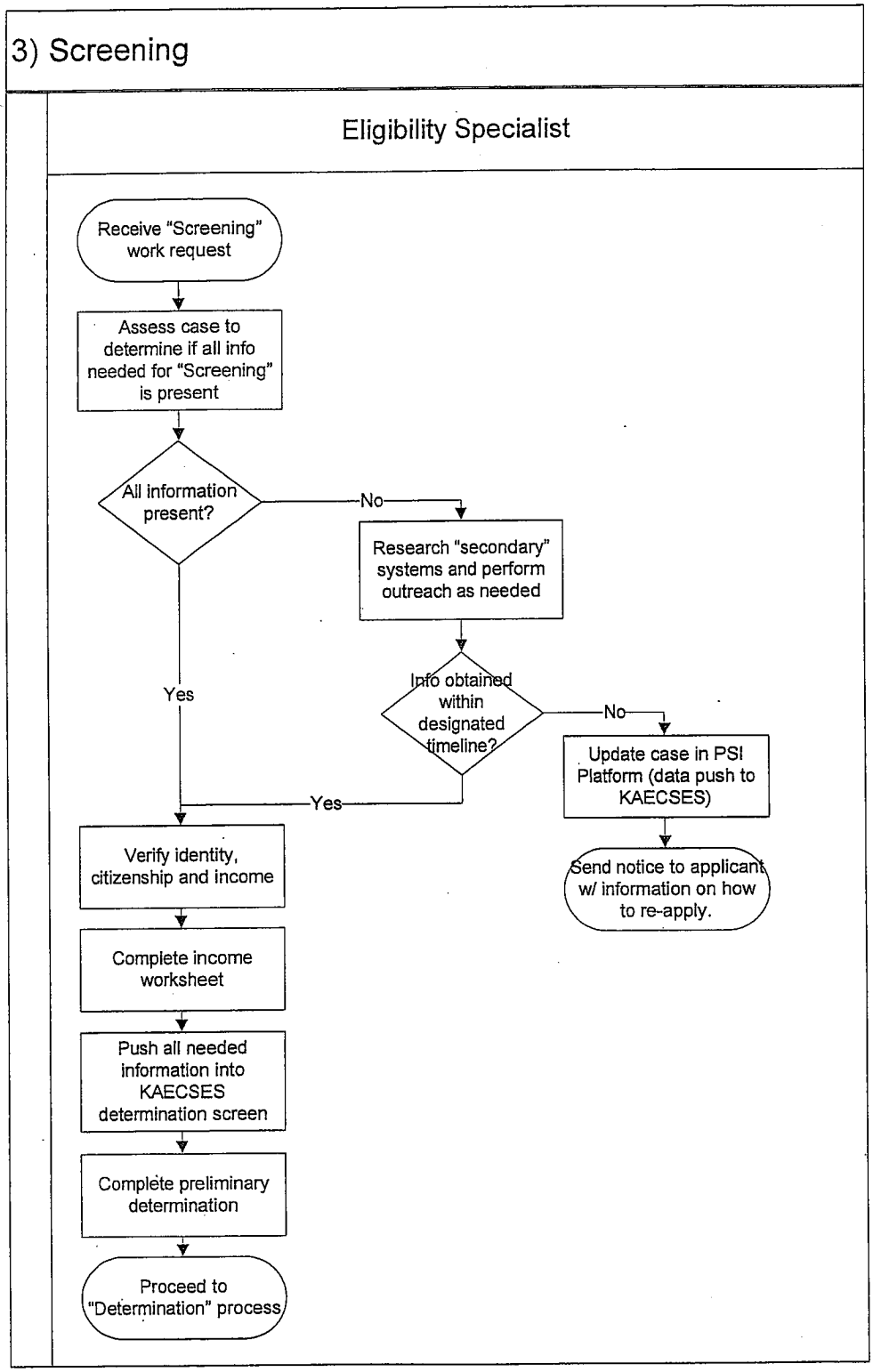
Kansas HealthWave Clearinghouse High Level Workflow



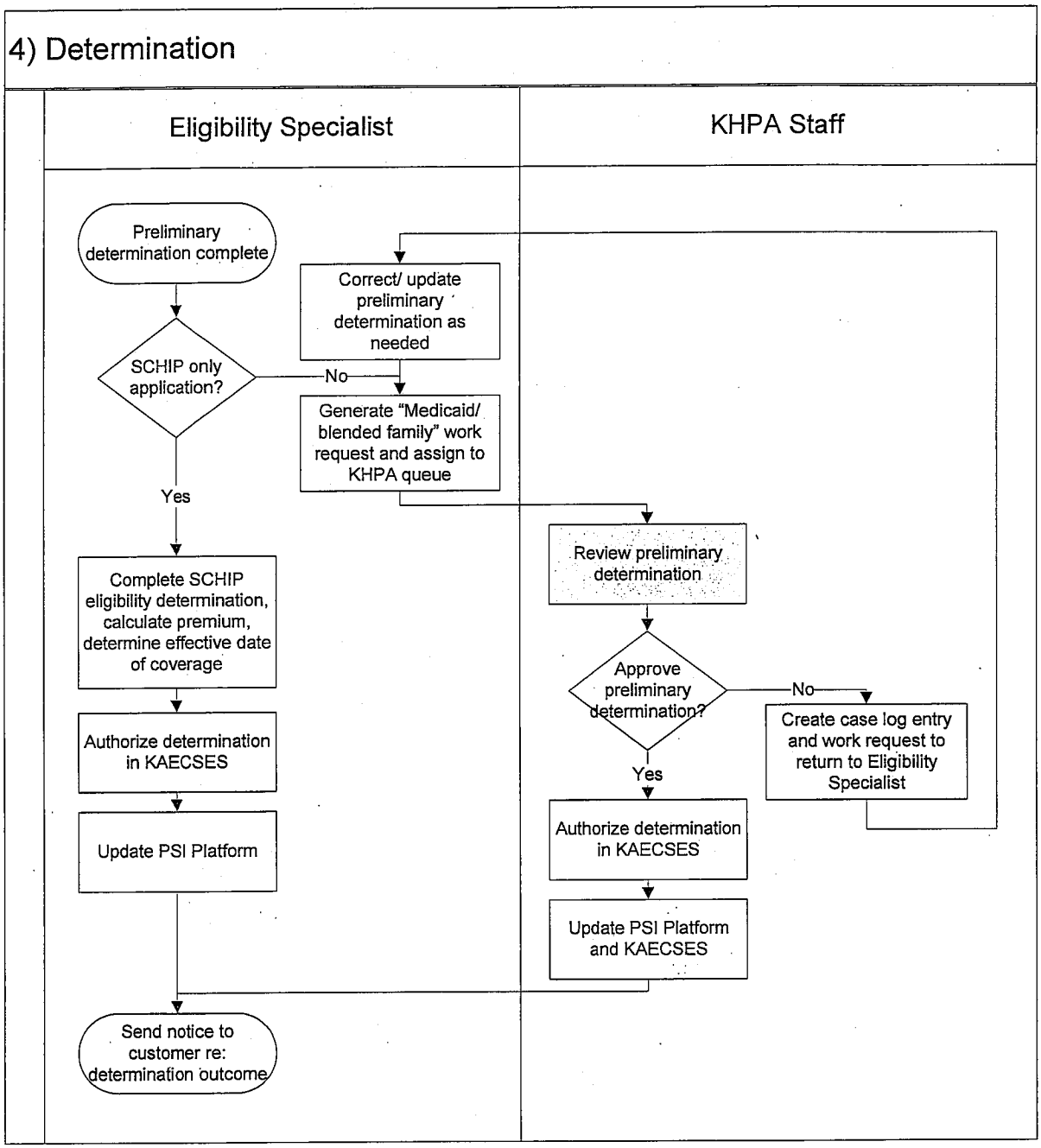
Kansas HealthWave Clearinghouse High Level Workflow



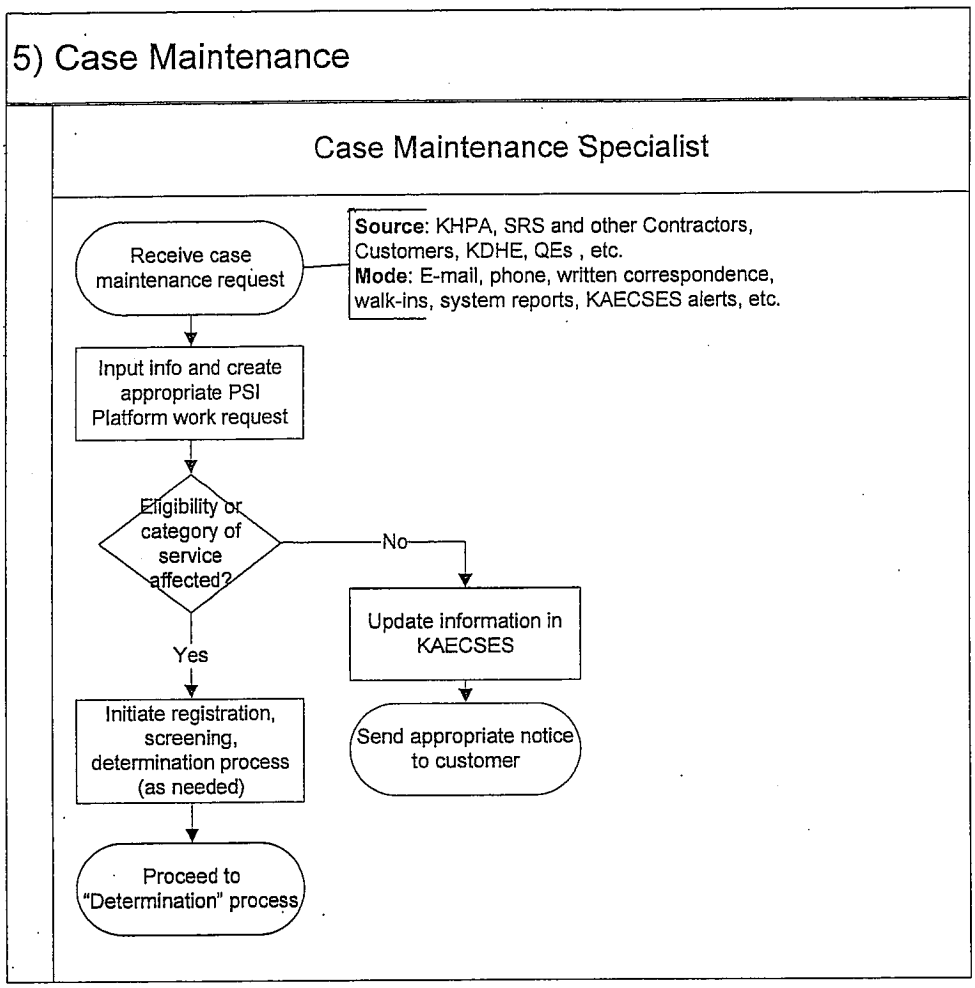
Kansas HealthWave Clearinghouse High Level Workflow



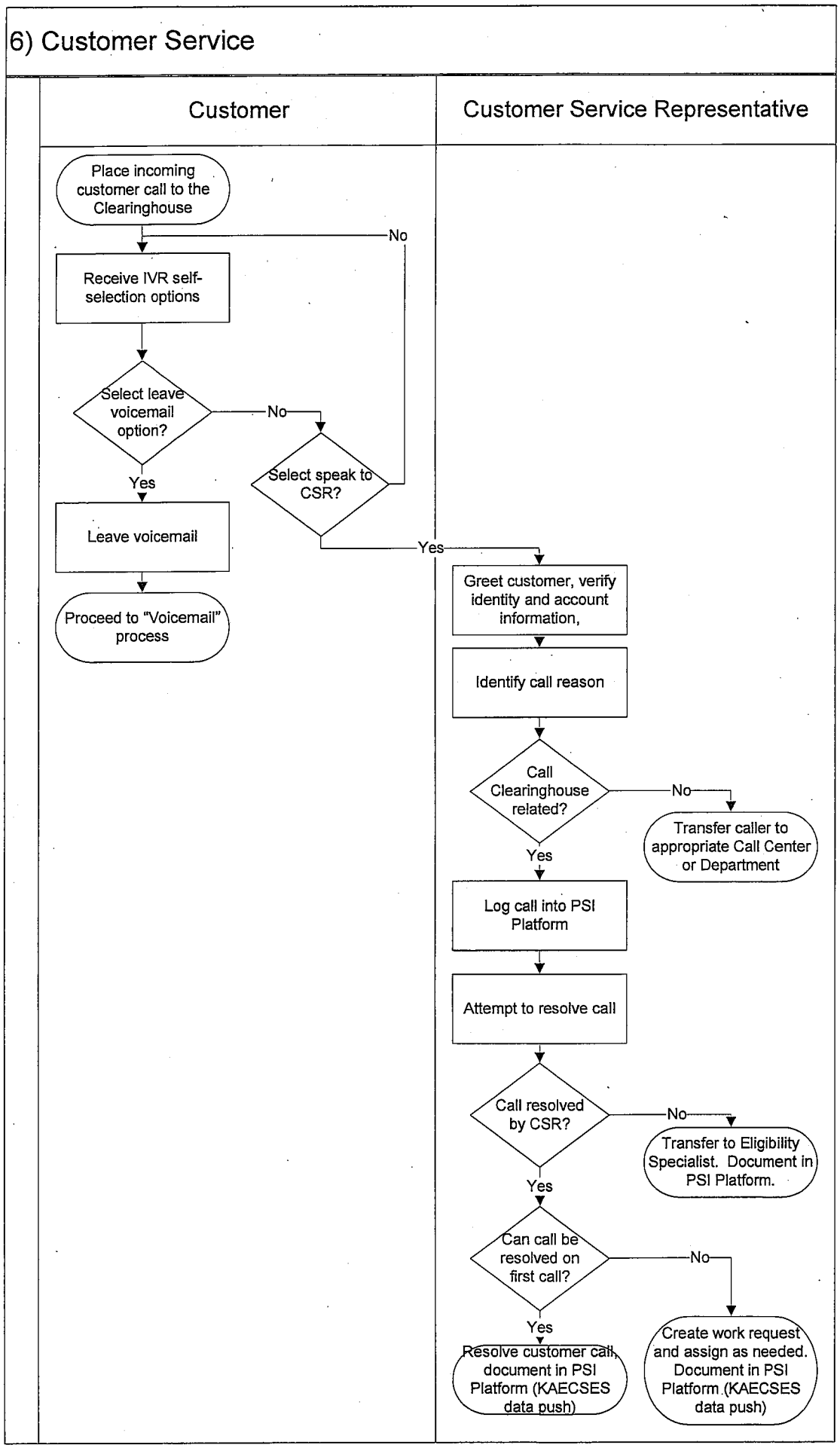
Kansas HealthWave Clearinghouse High Level Workflow



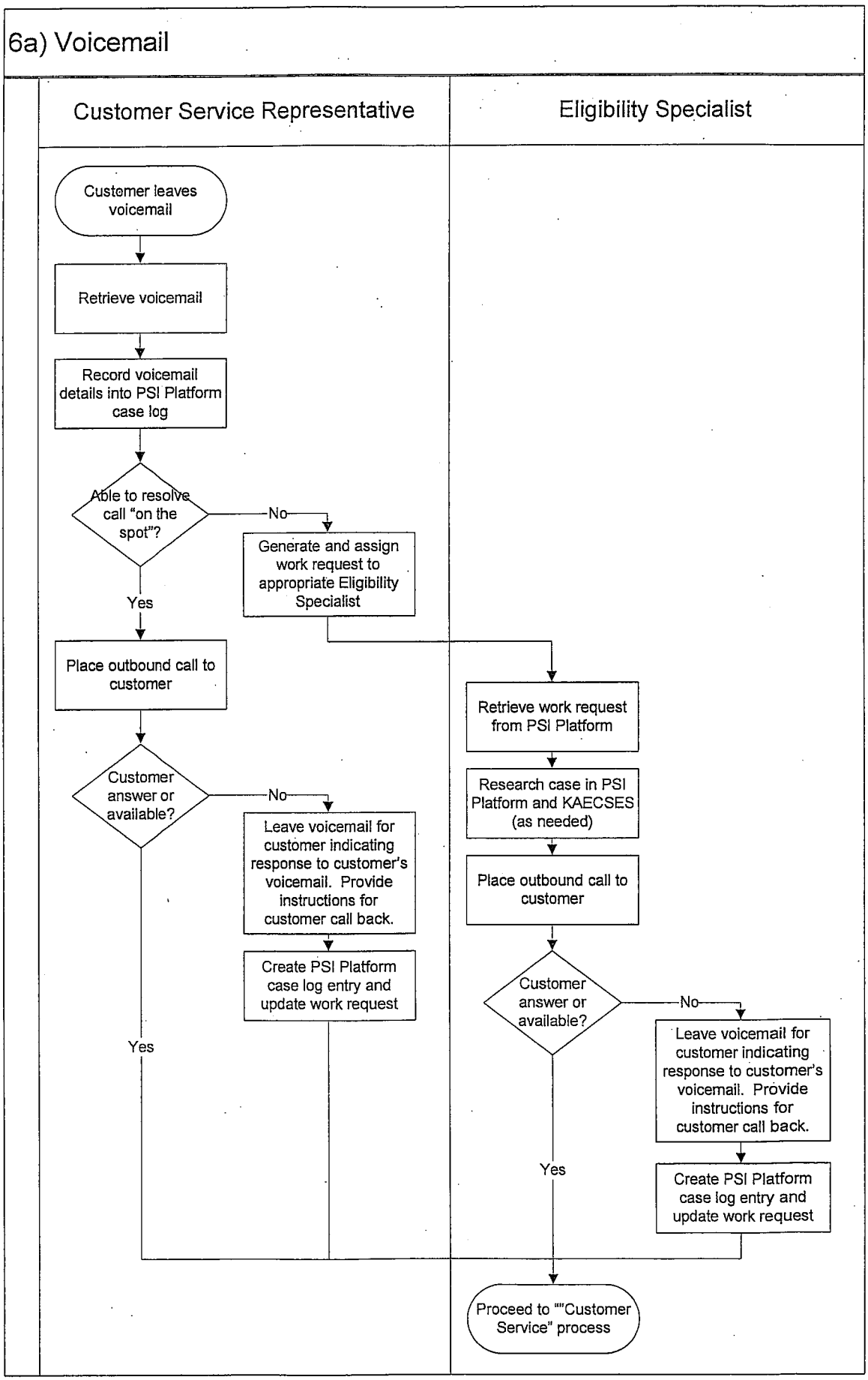
Kansas HealthWave Clearinghouse High Level Workflow



Kansas . . ealthWave Clearinghouse High Level Workflow



Kansas HealthWave Clearinghouse High Level Workflow



12-8

KANSAS
JUVENILE JUSTICE AUTHORITY

Mark Parkinson, Governor
Dennis A. Casarona, Acting Commissioner
jja.ks.gov

TESTIMONY ON THE NO PLACE LIKE HOME GRANT TO THE JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT BY DIRECTOR OF COMMUNITY PROGRAMS RANDY BOWMAN KANSAS JUVENILE JUSTICE AUTHORITY DECEMBER 9, 2010

In October 2009, Keys for Networking, Inc. was awarded a federal Children's Health Insurance Program Reauthorization Act (CHIPRA) Outreach Grant and approached the Juvenile Justice Authority (JJA) to collaboratively assist in the enrollment of uninsured Kansas JJA youth and families for either Medicaid or the Children's Health Insurance Program (CHIP). This is a joint collaborative to benefit the lives of at-risk youth and their families, with no fiscal impact to the agency.

In December 2009, a memorandum of understanding regarding the CHIPRA Grant, referred to as the No Place Like Home Grant, was signed between Keys for Networking, Inc. and the JJA. In the following weeks a referral form, release of information form and pamphlet describing the available services were developed. In January 2010, the JJA released a memorandum to its community partners regarding the No Place Like Home Grant implementation.

The Juvenile Justice Authority continues to collaborate with Keys for Networking, Inc. to discuss, promote and expand the opportunities for the remainder of the No Place Like Home Grant. With the positive outcomes being achieved for youth and families, the referral population was expanded to Juvenile Intensive Supervised Probation youth and soon will be expanded again to youth and families accessing the Juvenile Intake and Assessment programs across the State of Kansas.

714 SW Jackson, Ste. 300; Topeka, KS 66603 • (785) 296-4213 • Fax:
e-mail: jja@jja.ks.gov

Assuring youth under the supervision of JJA secure services and resources to pay for them

JJA•KHPA•Keys for Networking PARTNERSHIP

December 9, 2010

1

Purpose of Partnership

1. Determine eligibility for Medicaid/Healthwave youth under the custody of KS JJA

2. Help youth/family find services needed to
   --comply with court orders
   --reintegrate with family, school, community

2

Going Forward

CMS has approved program expansion

JJA invited effective December 3, youth from intake and assessment

3

Total Families and Youth

837
Total Families Referred to Keys

837
JJA Youth
Referred by CSO

791
Sibling/offspring/family member
Added by parent of JJA Youth

1,628
Total Youth

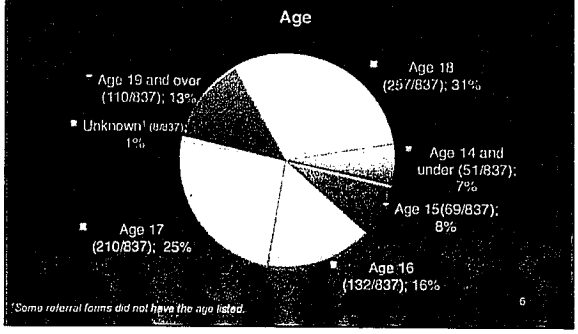
4

Ways we learned to find parents

- Call same day as referral
- Send thinking of you cards, when no response
- Use Facebook
- Use internet pipl and Intellius search
- Call schools and ask for contact information
- Ask community supervision officers for additional background information
- Call often, different times of day, different days

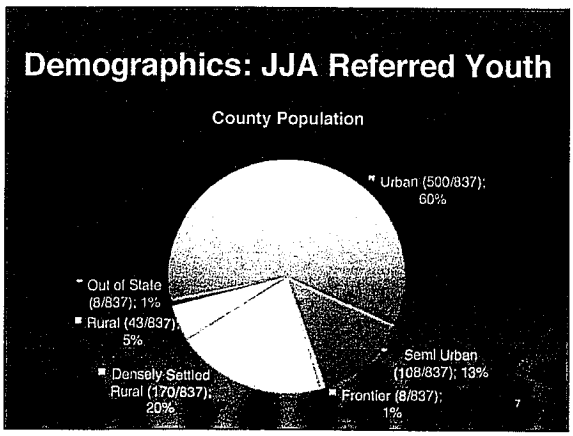
5

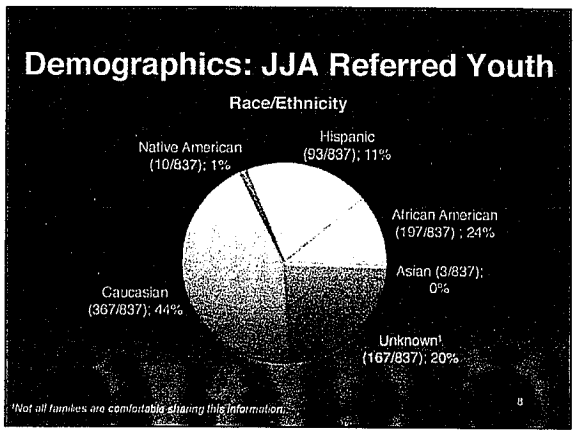
Demographics: JJA Referred Youth

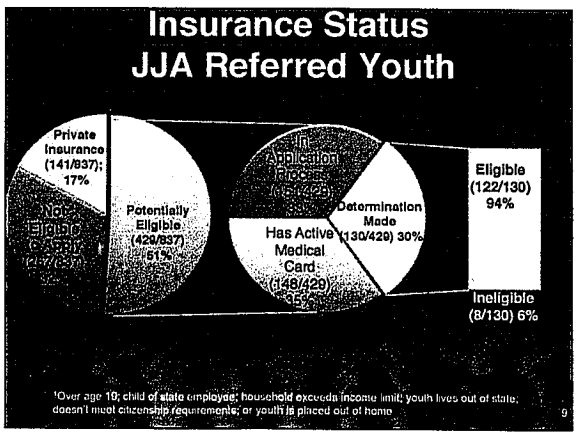


[1]Some referral forms did not have the age listed.

6


Demographics: JJA Referred Youth
County Population
Urban (500/837); 60%
Semi Urban (108/837); 13%
Frontier (8/837); 1%
Densely Settled Rural (170/837); 20%
Rural (43/837); 5%
Out of State (8/837); 1%
7


Demographics: JJA Referred Youth
Race/Ethnicity
Native American (10/837); 1%
Hispanic (93/837); 11%
African American (197/837) ; 24%
Asian (3/837); 0%
Caucasian (367/837); 44%
Unknown¹ (167/837); 20%
¹Not all families are comfortable sharing this information.
8


Insurance Status
JJA Referred Youth
Private Insurance (141/837); 17%
Potentially Eligible (429/837) 51%
Has Active Medical Card (149/429) 35%
Determination Made (130/429) 30%
Eligible (122/130) 94%
Ineligible (8/130) 6%
¹Over age 19; child of state employee; household exceeds income limit; youth lives out of state; doesn't meet citizenship requirements; or youth is placed out of home
9

Health Needs Identified

70% of families contacted have reported the following issues:

- 73% report Mental Health needs
- 48% report Physical Health needs
- 35% report Substance Abuse of needs

Needs identified are a factor of how well we connect with family

10

Our process

- Contact each family by phone day of referral
- Assign peer mentor (experience with corrections)
- Interview for perceived needs, court ordered services, current insurance, follow up to assure access
- Locate application, move it forward
- Complete application, compile supporting documents
- Send completed application form to parents for approval and signature
- Submit to KHPA
- Follow up/meetings with KHPA Liaison/Clearinghouse

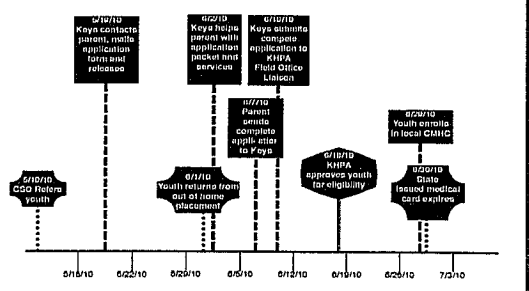
11

Time Issues Related to Insurance

- State Issued Medical Card Expires:
  - On the last day of the month if the youth returns home before the 15th.
  - On the last day of the following month if the youth returns home after the 15th.

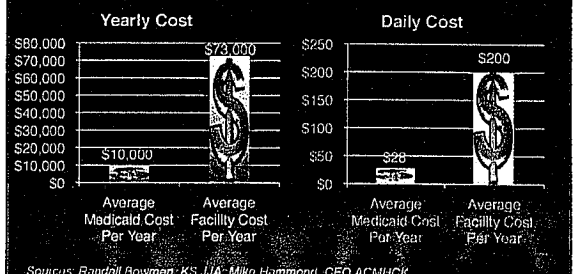
12

Timeline: Continuous Coverage



13

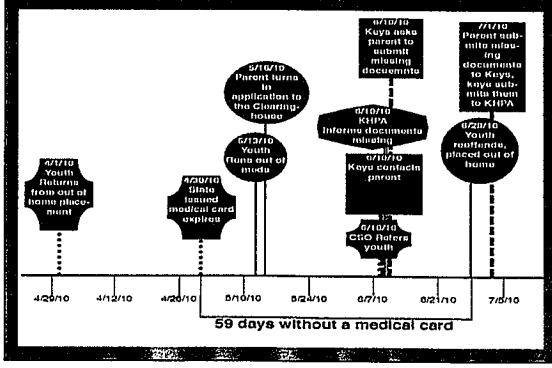
Coverage Lapses Cost the State



Sources: Randall Bowman, KS JJA; Mike Hammond, CEO ACMHCK

14

Timeline: Coverage Lapses



15

14-5

Card Delays: Cost to youth, family

- Loss of freedom
- Loss of community resources
- Loss of school, academic services
- Loss of credits
- Loss of mental health/substance abuse treatment providers they know
- Loss of family

16

Program Successes

- 18[1] day turn around

(record is 1 hour from referral to approval)

- 94% approval rate

[1]Average reflects applications referred to the field office liaison

17

Problems families experience using card

- Hard to find medical providers who accept the card and providers who offer needed services
- Substance abuse treatment
- Dental

18

Primary uses of the card

- Securing mental health services-therapy
- Filling medications for ADHD, depression
- Securing substance abuse evaluations and treatment
- Connecting to dental care
- Completing pre/post natal visits
- Transportation

Source: Fall 2010 NPLH Survey

19

How we did it

- Employ parents who share the experience of our clients
- Discuss use of medical card/service options
- Help families connect to the services
- Teach families to secure quality services and monitor youth outcomes
- Build technology to house records, autofill applications, self-help feature for 2011
- State Agency Support

20

What worked

The American Institute for Research reports that Keys' informed/engaged parents are more likely to enroll/ stay enrolled at the .05 significance level than parents who receive assistance only at their request.

21

Parent Thoughts

From the Fall 2010 NPLH Survey

22

"Keys made the process of obtaining a medical card for my children almost effortless."

"Keys make me feel like I'm not alone in with my daughter's problems."

"Thank you!!! I no longer have a reason not to take my child to the doctor. I have insurance and transportation. It makes me feel better knowing I'm providing for them. Because of your caring staff."

"I appreciated your assistance in getting the medical card. I was not getting anywhere with it myself. The card has allowed my son to get in the treatment program that is helping him."

Before help from Keys, getting a medical card "was difficult and hard. I had given up."

"I have had a very difficult time obtaining medical insurance. Keys made the process almost stress-less."

23

Thank you

Kansas Health Policy Authority

Kansas Juvenile Justice Authority
and
Community Supervision Officers from
31 Kansas Districts

24

KAMU
THE PRIMARY CARE ASSOCIATION OF KANSAS
unity
advocacy

Testimony on:

Coordinating Grant Opportunities in Kansas

Presented to:

Health Policy Oversight Committee

By:

Cathy Harding, Executive Director
Kansas Association for the Medically Underserved

December 9, 2010

For additional information contact:

KAMU
1129 S Kansas Ave., Ste. B
Topeka, KS 66612
Ph: (785) 233-8483
Fax: (785) 233-8403

Good morning Madam Chair and members of the Health Policy Oversight Committee. I am Cathy Harding, Executive Director for the Kansas Association for the Medically Underserved (KAMU). KAMU has been recognized nationally by the Bureau of Primary Health Care (HHS, HRSA) as the Primary Care Association of Kansas (PCA) since 1991. We represent 39 Primary Care Safety Net Clinics in Kansas and in 2009 these clinics provided primary health care to over 223,000 Kansans. From 2008 – 2009, the primary care safety net clinics of Kansas saw a 17% increase in visits.

I am here today to visit with you about offering a solution to a request that was made at your last oversight committee meeting. Following a presentation by Teresa Brooks, of Polsinelli Shughart PC, regarding all the pilots, demonstrations, and grants that are and will become available to states through the Patient Protection and Affordable Care Act, a question was raised by one of the members of your committee on who in Kansas is coordinating all of these opportunities so Kansas receives its fair share of the grants available.

KAMU offered to assist in this endeavor. Representative Bethell and members of this committee then asked us to come back today and provide you our suggested plan on accomplishing this task.

Today, as this committee requested, I'll outline KAMU's plan to monitor the opportunities available through the Affordable Care Act (ACA) and to communicate with key agencies, associations and organizations in the state, with the goal of securing as many resources as possible to benefit the people of Kansas.

KAMU Plan to Track Opportunities in the ACA to Benefit Kansans:

- Add one staff person at KAMU to devote approximately .5 FTE toward monitoring the opportunities of the ACA.
- Add a link to the KAMU website dedicated to ACA opportunities, and provide the website link to associations, organizations, and governmental entities involved in health care services.
- Form an ACA Advisory Group to determine what entities should be actively contacted and encouraged to pursue identified opportunities.

Madam Chair and members of the committee – currently our budget allows for a staff member to devote a portion of his or her time to coordinate this effort, but this work will be possible only if current funding levels remain. KAMU is committed to this effort and will continue to do everything we can to continue the coordination of ACA program and grant opportunities, but do want to emphasize that this will only be possible with our current funding level.

I'll stand for questions.

KANSAS

KANSAS DENTAL BOARD

Mark Parkinson, Governor
Betty Wright, Executive Director

www.kansas.gov/kdb

Testimony re: Shortage of Medicaid Dentists and Corporate Dentistry in Kansas
Joint Committee on Health Policy Oversight
Presented by Betty Wright
December 9, 2010

Chairperson and Members of the Committee:

My name is Betty Wright, and I am the Executive Director of the Kansas Dental Board. The Board consists of nine members: six dentists, two dental hygienists and one public member. The mission of the Dental Board is to protect the public through licensure and regulation of the dental profession.

The Board has been entrusted with enforcing the Dental Practices Act in order to protect the public. We have no voice or stand on the issue of Medicaid providers or reimbursements. In fact there are three references to Medicaid in the Kansas Dental Practices Act (KDPA) are (1) allowing dentists to be employed by FQHCs and indigent clinics who accept Medicaid:

K.S.A.65-1466. Dental services for dentally indigent persons; entities authorized to employ or contract with persons licensed under dental practices act for such services; reports by federally qualified health centers and clinics employing a national health service corps dentist; requirements for retired dentists providing such dental services. (a) (1) Notwithstanding any other provision of the dental practices act, a not-for-profit corporation having the status of an organization under 26 United States Code Annotated 501(c)(3) which is also a facility qualified under subsection (b) of K.S.A. 65-431 and amendments thereto to select and employ professional personnel, an indigent health care clinic as defined by the rules and regulations of the secretary of health and environment, or a local health department may employ or otherwise contract with a person licensed under the dental practices act to provide dental services to dentally indigent persons.

(2) Notwithstanding any other provision of the dental practices act, a federally qualified health center or national health service corps site may employ or otherwise contract with a person licensed under the dental practices act to provide services to any person except that a federally qualified health center and a clinic employing a national health service corps dentist shall report annually to the health care reform legislative oversight committee indicating the income level of their patients and the percentage of patients covered by dental insurance in the preceding year.

(b) Dentally indigent persons are those persons who are: (1) Determined to be a member of a family unit earning at or below 200% of poverty income guidelines based on the annual update of "poverty income guidelines" published in the federal register by the United States department of health and human services and are not indemnified against costs arising from dental care by a policy of accident and sickness insurance or an employee health benefits plan; or (2) eligible for **Medicaid**; or (3) eligible for the Kansas federal children's health insurance program; or (4) eligible for other publicly funded health care programs as defined by the Kansas dental board; or (5) qualified for Indian health services. This subsection shall not be construed to prohibit an entity under subsection (a) which enters into an arrangement with a licensee under the dental practices act for purposes of providing services to dentally indigent persons pursuant to subsection (a) from defining "dentally indigent persons" more restrictively than such term is defined under this subsection.

(c) A licensee under the dental practices act who enters into an arrangement with an entity under subsection (a) to provide dental services pursuant to subsection (a): (1) Shall not be subject to having the licensee's license suspended or revoked by the board solely as a result of such arrangement; and (2) may not permit another person who is not licensed in Kansas as a dentist, and is not otherwise competent, to engage in the clinical practice of dentistry. No entity under subsection (a) or any other person may direct or interfere or attempt to direct or interfere with a licensed dentist's professional judgment and competent practice of dentistry.

And (2), hygienists with extended care permits may provide services to children who qualify for Medicaid:

KSA 65-1456. Dental hygienists; suspension or revocation of licenses, when; notice and hearing; practice of dental hygiene defined; rules and regulations; supervision defined; where performance of practice authorized, issuance of permits therefor; authorized activities, requirements. (a) The board may suspend or revoke the license of any dentist who shall permit any dental hygienist operating under such dentist's supervision to perform any operation other than that permitted under the provisions of article 14 of chapter 65 of the Kansas Statutes Annotated,

or acts amendatory thereof, and may suspend or revoke the license of any hygienist found guilty of performing any operation other than those permitted under article 14 of chapter 65 of the Kansas Statutes Annotated, or acts amendatory thereof. No license of any dentist or dental hygienist shall be suspended or revoked in any administrative proceedings without first complying with the notice and hearing requirements of the Kansas administrative procedure act.

... (f) The practice of dental hygiene may be performed with consent of the parent or legal guardian, on children participating in residential and non-residential centers for therapeutic services, on all children in families which are receiving family preservation services, on all children in the custody of the secretary of social and rehabilitation services or the commissioner of juvenile justice authority and in an out-of-home placement residing in foster care homes, on children being served by runaway youth programs and homeless shelters; and on children birth to five and children in public and nonpublic schools kindergarten through grade 12 regardless of the time of year and children participating in youth organizations, so long as such children birth to five, in public or nonpublic schools or participating in youth organizations also meet the requirements of **medicaid,** healthwave, or free or reduced lunch programs or Indian health services; at any state correctional institution, local health department or indigent health care clinic, as defined in K.S.A. 65-1466, and amendments thereto, and at any federally qualified health center, federally qualified health center look-alike or a community health center that receives funding from section 330 of the health center consolidation act, on a person, inmate, client or patient thereof and on other persons as may be defined by the board; so long as:

(1) The dental hygienist has received an "extended care permit" from the Kansas dental board specifying that the dental hygienist has performed 1,200 hours of dental hygiene care within the past three years or has been an instructor at an accredited dental hygiene program for two academic years within the past three years;

(2) the dental hygienist shows proof of professional liability insurance;

(3) the dental hygienist is sponsored by a dentist licensed in the state of Kansas, including a signed agreement stating that the dentist shall monitor the dental hygienist's activities, except such dentist shall not monitor more than five dental hygienists with an extended care permit;

(4) the tasks and procedures are limited to: (A) removal of extraneous deposits, stains and debris from the teeth and the rendering of smooth surfaces of the teeth to the depths of the gingival sulci; (B) the application of topical anesthetic if the dental hygienist has completed the required course of instruction approved by the dental board; (C) the application of fluoride; (D) dental hygiene instruction; (E) assessment of the patient's apparent need for further evaluation by a dentist to diagnose the presence of dental caries and other abnormalities; and (F) other duties as may be delegated verbally or in writing by the sponsoring dentists consistent with this act;

(5) the dental hygienist advises the patient and legal guardian that the services are preventive in nature and do not constitute a comprehensive dental diagnosis and care;

(6) the dental hygienist provides a copy of the findings and the report of treatment to the sponsoring dentist and any other dental or medical supervisor at a participating organization found in this subsection; and supervisor at a participating organization found in this subsection; and

(7) any payment to the dental hygienist for dental hygiene services is received from the sponsoring dentist or the participating organization found in this subsection. ...

Finally (3) the mobile dentistry regulations require the operator to notify patients that their treatment may affect their Medicaid benefits:

KAR 71-8-5. Written procedures; communication facilities; conformity with requirements; driver requirements; consent forms; follow-up treatment. Each operator of a mobile dental facility or portable dental operation shall ensure that the following conditions and requirements are met:

(a) A written procedure for emergency follow-up care is used for patients treated in the mobile dental facility or portable dental operation, and the procedure includes arrangements for treatment in a health care facility that is permanently established in the area where services were provided.

(b) The mobile dental facility or portable dental operation has communication facilities that will enable the operator to contact necessary parties if a medical or dental emergency occurs. The communications facilities shall enable the patient or the parent or guardian of the patient treated to contact the operator for emergency care, follow-up care, or information about treatment received. The health care provider who renders follow-up care shall also be able to contact the operator and receive treatment information, including radiographs when taken.

(c) The mobile dental facility or portable dental operation and the dental procedures performed meet the requirements of K.A.R. 71-1-18.

(d) The driver of the mobile dental facility or portable dental operation possesses a valid driver's license appropriate for the operation of the vehicle.

(e) No services are performed on minors or individuals for whom a guardian has been established without a signed consent form signed by the parent or guardian that includes the following:

(1) An authorization for the treatment to be provided;

(2) an acknowledgement by the parent or guardian that the treatment of the patient at the mobile dental facility or portable dental operation could affect the future benefits that the patient could receive under any of the following:

(A) Private insurance;

(B) medicaid; or

(C) a children's health insurance program; and

(3) an acknowledgement by the parent or guardian that the parent or guardian has been advised to arrange for continued dental care for the patient.

CORPORATE DENTISTRY

The remaining topic for this committee is on the Kansas law regarding corporate dentistry. There are five provisions in the KDPA that limit corporate ownership. (1) Dentists may not be employed by an unlicensed proprietor; (2) corporations may not practice dentistry (3) dentists may not split fees with a non-dentist; (4) dentist(s) owners must be in the practice a majority of the time the office is operated; (5) and franchises are prohibited.

(1) If the dentist works for a corporation, the corporation is considered to be practicing dentistry as an unlicensed proprietor. Unless a dentist is employed by another dentist or a professional dental corporation or by certain exceptions such as indigent health care clinics, FQHCs, or state institutions, the dentist is in violation pursuant to:

KSA 65-1424. Proprietor defined; revocation of license, when. The term "proprietor" as used in this act includes any person who:

(a) Employs dentists or dental hygienists in the operation of a dental office; or

(b) places in possession of a dentist or dental hygienists or other agent such dental material or equipment as may be necessary for the management of a dental office on the basis of a lease or any other agreement for compensation for the use of such material, equipment or offices; or

(c) retains the ownership or control of dental equipment or material or office and makes the same available in any manner for the use by dentists or dental hygienists or other agents except that nothing in this subsection (c) shall apply to bona fide sales of dental equipment or material secured by a chattel mortgage or retain title agreement.

A licensee of dentistry who enters into any of the above-described arrangements with an unlicensed proprietor may have such license suspended or revoked by the board.

(2) Before enacting KSA 65-1425 below against corporate dentistry, early case law described a public policy against corporations practicing medicine and dentistry. In Winslow v. Board of Dental Examiners, 115 Kan. 450 (1924) the Supreme Court said ""[c]orporations may not be graduated from dental colleges, they have neither learning nor skill, and they may not be examined, registered or licensed as dentists. Therefore, the legislature does not permit the organization of a domestic corporation to practice dentistry." The Court said the prohibition was to protect the public. In the Winslow case, the dentist's license was revoked for being employed by a corporation – receiving a salary and commission for dental work on the corporation's clients.

KSA 65-1425. Corporations not to practice dentistry; exception; employee to display name. Except as provided in K.S.A. 17-2706 *et seq.*, **no corporation shall practice, offer, or undertake to practice or hold itself out as practicing dentistry.** Every person practicing dentistry as an employee of another shall cause his name to be conspicuously displayed and kept in a conspicuous place at the entrance of the place where such practice is conducted: *Provided, however,* That nothing herein contained, shall prohibit a licensed dentist from practicing dentistry as the agent or employee of another licensed dentist in this state, or from practicing dentistry as the agent or employee of any state hospital or state institution where his only remuneration is from the state, or from any corporation which provides dental service for its employees at no profit to the corporation.

(3) The division of dental fees is a violation, some business models in which a corporation shares in the profits of a dentist may be considered as fee splitting with a corporation, also the process of "bonuses" for staff when patients are converted to more profitable procedures, can be viewed as a violation of the KDPA:

KSA 65-1436. **Grounds for refusal to issue license or for action against license of dentist or dental hygienist; disciplinary action by board; notice and hearing; professionally incompetent defined; physical or mental examination.** (a) The Kansas dental board may refuse to issue the license provided for in this act, or may take any of the actions with respect to any dental or dental hygiene license as set forth in subsection (b), whenever it is established, after notice and opportunity for hearing in accordance with the provisions of the Kansas administrative procedure act, that any applicant for a dental or dental hygiene license or any licensed dentist or dental hygienist practicing in the state of Kansas has:

... (7) engaged in the division of fees, or agreed to split or divide the fee received for dental service with any person for bringing or referring a patient without the knowledge of the patient or the patient's legal representative, except the division of fees between dentists practicing in a partnership and sharing professional fees, or in case of one licensed dentist employing another;

(4) In order to assure that the dentist owner is overseeing the operations of the office, and is accountable to the board and to the patients, **all owners of a dental practice are to be present in the office a majority of the time the office is operating**, except for a recent change in order to alleviate access to care issues in rural areas, there is an exception to the majority presence rule (g), but most dentists must comply see (d) below:

KSA 65-1435. **Improper use of certain names by dentists; exceptions; unlawful acts; suspension or revocation of license.** (a) Except as otherwise provided in this section, it shall be unlawful for any person or persons to practice or offer to practice dentistry under any name except such person's own name, which shall be the name used on the license granted to such person as a dentist as provided in this act, or to use the name of any company, association, corporation, clinic, trade name or business name in connection with the practice of dentistry as defined in this act.

... (d) It shall be unlawful, and a licensee may have a license suspended or revoked, for any licensee to conduct a dental office in the name of the licensee, or to advertise the licensee's name in connection with any dental office or offices, or to associate together for the practice of dentistry with other licensed dentists in a professional corporation or limited liability company, under a name that may or may not contain the proper name of any such person or persons or to associate together with persons licensed to practice medicine and surgery in a clinic or professional association under a name that may or may not contain the proper name of any such person or persons and may contain the word "clinic," **unless such licensee is personally present in the office operating as a dentist or personally overseeing such operations as are performed in the office or each of the offices during a majority of the time the office or each of the offices is being operated.**

(e) Nothing in this section shall be construed to **permit the franchise practice of dentistry.**

(f) The violation of any of the provisions of this section by any dentist shall subject such dentist to suspension or revocation of a license.

(g) Notwithstanding the provisions of subsections (d) and (e), a licensee shall be permitted to own two dental offices in addition to the licensee's primary office location under the following conditions:

(1) The licensee's secondary dental office is located within a 125 mile radius of the licensee's primary office; and

(2) the licensee's secondary dental office is located in a county with a population of less than 10,000 according to the 2000 United States census.

(5) The KDPA is clear that **franchise dentistry**, another form of corporate dentistry, is prohibited – pursuant to (e) above.

The purpose of these restrictions on the corporate practice of dentistry are to assure that the dentist is in control of the office itself; and is in control of the treatment decisions for the patients. The legislation was enacted to hold the dentist accountable for the direct care of the patient. Once the dentist becomes simply an employee, or absentee owner, the office focus tends to be on maximizing profits, rather than maximizing care for the patient. The Kansas law intentionally creates a dental care system that is a "cottage industry" where the dental home of the patient is owned and operated by the provider of care. The business model is intentionally restrictive, so that the dentist owner is accountable to the board. If corporations and other absentee owners are in charge; they tend to demanding lower quality materials, higher patient volumes, and/or shorter patient treatment times the employed dentists are placed in the position of a poorer standard of care. The board would not have authority over the root cause of the problem, but the practitioner who is subject to the pressure must uphold professional standards. Kansas laws and regulations are currently in the best interest of the public.

I will be glad to answer any questions from the committee.

Respectfully submitted,

Betty Wright
Executive Director

betty.wright@dental.state.ks.us

Date: December 9, 2010

To: Joint Committee on Health Policy Oversight

From: Kevin J. Robertson, CAE
Executive Director

RE: Medicaid Dentists and Corporate Ownership of Dental Practices

Chairman Landwehr and members of the committee I am Kevin Robertson, Executive Director of the Kansas Dental Association representing 1,250, or some 77% of the state's licensed dentists. Thanks for the opportunity to discuss with you the Kansas Dental Associations' thoughts on dental Medicaid and corporate dentistry.

According to the Dental Provider Participation Analysis reports compiled by the Kansas Health Policy Authority the number of Medicaid recipients receiving dental care has increased...by more than 11% from June 2008 to June 2009 and by about another 9% from June 2009 to June 2010.

About 600 dentists or 40% of the 1,430 practicing dentists in Kansas are enrolled Medicaid providers. Of those, around 350 or 25% of Kansas dentists are active Medicaid providers that have treated patients within the past year. These numbers include approximately 57 orthodontists, 31 endodontists, 34 periodontists and 10 other dental specialties that would have very little or no ability to provide care in a children's-only system. In 2009, these Medicaid dentist providers treated **70%** of the children enrolled in Medicaid 20 years of age and under!

Delta Dental Plan of Kansas is by far the largest dental insurance company in Kansas with 850,000 insured lives and a provider network that consists of 91% of all the dentists in the state. Most of you would agree that an employed Kansan with Delta Dental insurance has dental access, yet Delta reports that only about 50% of its dental insurance policy holders and their dependents see a dentist in a given year.

There have been and are numerous obstacles for dentist Medicaid providers including a 10% reimbursement rate cut last year (since restored), discontinued funding of the Frail and Elderly, Pregnant Mothers and Developmentally Disabled HCBS waivers, an overall reimbursement rate of 56% of actual dental fees on procedures when dental office overhead averages 60.5%, no overall rate increases since 1999 while regular inflation has increased 31% in that time, the elimination of all Medicaid dental provider support has left many dentists without assistance and no one is actively recruiting new provider dentists.

In addition to these issues, many dentists express concerns about standard procedures that are not reimbursed by Medicaid which are often still completed on patents with no reimbursement whatsoever. In 2009, the Division of Medicaid began "recoupment" proceedings against several dental providers to recoup thousands of dollars in past payments to Medicaid for simply filing claims as per standard ADA CDT procedure. The decision was later made not to pursue recoupment, however, this story is now infamous in the chronicles of Kansas Dental Medicaid and has joined many other similar instances that warn dentists to steer clear!

Another obstacle is the 163-page dentist provider manual for Medicaid which appears quite foreboding to prospective dental providers. By comparison, the Delta Dental provider manual is 65 pages long.

This past August, the KDA recruited 55-60 dental offices in a short two week period to participate in an adult dental program at Medicaid rates prior to Sept. 30. This was not Medicaid, but the dentist response shows that dentists are willing to provide care even at lower rates when called upon!

The KDA is very interested in improving Kansas Medicaid to make it a more workable model for dentists and patients to maximize the care available to Medicaid recipients. The KDA welcomes the opportunity to work with the legislature and KHPA on this. The KDA vision includes streamlining the provider contract and claims processing, adjusting provider rates to the same level as the state employee health plan, allowing more freedom for Medicaid patients to choose a dentist and developing better case management that will work to reduce the Medicaid no-show rate of 35-40% versus 6% for other dental patients.

It is the KDA's hope to work with the legislature and KHPA to develop a plan to significantly increase the number of active Medicaid providers.

The KDA supports expansion of dental Medicaid to include adult Kansans. Currently, the dentists of Kansas fund, administer and support perhaps the only two programs for adult dental care in Kansas through the Donated Dental Services (DDS) program and the Kansas Mission of Mercy (KMOM) Dental Project. State funding for the DDS Program was cut by the Kansas Health Policy Authority (KHPA) in 2009 after 13 years of support. Private grants and personal funding by dentists have been raised to continue the program through FY 2011. DDS' 350 dental providers complete approximately $500,000 in free dental care each year to mostly disabled and elderly patients. The administrative cost of this program is $70,000.

The annual KMOM Dental Project administered by the KDA's own Kansas Dental Charitable Foundation (KDCF) consistently provides about 1,800 patients with around $1 million in free dental care per year. KMOM has never received a government grant or tax-based support with the exception of local law enforcement or government facilities that from time to time are donated for the event. It costs approximately $60,000 annually to put on a KMOM Dental Project. In all, the nine KMOMs have provided care to 17,500 patients totaling $8.5 million. Nearly half of the dentists in Kansas have participated in at least one KMOM Dental Project. In all, it is estimated that the average dentist provides **$33,000** in charity and reduced-fee care to patients every year. That comes to **$46.3 million** in free and reduced care ANNUALLY given by Kansas Dentists to the people of Kansas!

It is somewhat difficult to address the issue of corporate dentistry since there is not a specific proposal being discussed. As a philosophy, however, the KDA supports licensed dentists owning, operating, and managing dental practices. This promotes the public welfare and best ensures that the line of

responsibility from the dentist to the patient is not broken. As such, the **KDA does not support the corporate practice of dentistry.** The type of payment mechanism or third party assistance does not affect the KDA's concerns regarding the corporate practice of dentistry.

The relationship of confidence between dentist and patients is essential to patient welfare and treatment success. The best interest of the patient should not be compromised as a result of a relationship or arrangement by a dentist working for an out of state corporation.

Decisions regarding the finances and profitability can create external pressures from owners on employee dentists that affect patient care. Such decisions should be made only by dentists, licensed by the Kansas Dental Board and accountable to the Board. The KDA fears that dentist's professional responsibilities may be undermined if a dentist is answerable to a corporate board of directors or lay managers. Some organizations may encourage under-treatment of patients in order to maximize the "bottom line," while others may encourage over-treatment with more expensive, marginally necessary procedures. Though I'm sure potential owners would argue that they would never interfere with the clinical judgment of a dentist, the promise of bonuses, ownership and advancement to a new graduate dentist can be as harmful to patient care decisions as edicts and quotas. It does not take a person long to find a plethora of Better Business Bureau complaints, blogs, news exposes and even attorney general consumer actions against dental corporations throughout the country. These complaints range from billing practices and fraud to poor patient care and abuse. You may want to do your own Google search to see for yourself.

Thank you for the opportunity to appear before you today. I would be happy to answer any questions at this time.

Testimony Presented To The Joint Committee on Health Policy Oversight

Lawless Barrientos: Comfort Dental

December 9, 2010

My name is Lawless Barrientos and I appear before you today on behalf of Comfort Dental. Comfort Dental is based out of Lakewood, Colorado and was founded by Dr. Rick Kushner in 1977. Dr. Kushner pioneered the concept of accessible, fair-priced dentistry. There are Comfort Dental practices in 7 states currently, including Colorado, Wyoming, Kentucky, New Mexico, Missouri, Ohio and Texas. It is critically important to note that Comfort Dental practices are privately owned and operated by dentists who are licensed in the states in which they practice. Comfort Dental practices epitomize the "family-friendly" concept.

- Collectively, Comfort Dental dentists see 1,500,000 patients per year. The Comfort Dental franchise has over 78 private practices and 286 partner dentists. Comfort Dental's mission is to provide quality, affordable dental care to all economic classes.
- Comfort Dental improves access by having extended office hours and 24-hour emergency access (Regular business hours generally are: Monday-Friday, 7:30 AM to 7:30 PM, Saturdays, 7:30 AM to 1:30 PM).
- Comfort Dental prices tend to be 40-60% lower than the average private practice dentist. Comfort Dental dentists make a point to go over dental prices and options with patients. Prices of dental procedures and care are posted to the consumer.
- The average dental Medicaid provider is well below the national average in Kansas. Comfort Dental is one of the largest Medicaid providers in Colorado. On average, Comfort Dental Private Practice Dentists treat approximately 40% under-insured/Un-insured, 20% Medicaid and CHIP +.

It is the success, and high-quality of Comfort Dental's family-friendly dental practice concept that has piqued the interest of several Kansas communities and licensed Kansas dentists who are interested in opening a Comfort Dental office in Kansas. With me today is Dr. Craig Bahr and Dr. Matt Draper. Dr. Matt Draper lives in Kansas along with several other Comfort Dental dentists, but they have to drive over the state line to practice in Missouri. They would like to open up a Comfort Dental practice in Kansas. We have worked closely with them in an effort to open a practice in Kansas, without success. I have also attached a letter to my testimony from the city of Colby who reached out to us in hopes of attracting an affordable, Medicaid-focused dental practice to their rural community.

As we attempted to work with the Kansas Dental Board to establish a Comfort Dental practice, we were disappointed that their interpretation of current law prohibits such a practice. We grew increasingly frustrated when there seemed to be at best, disinterest from the Dental Board in working with us to solve the problem, and at worst, hostility. In short, we were told to *"go to the legislature and change the law."*

So with some help from John Federico and his staff, that is what we will attempt to do in the 2011 Legislative Session. There is an obvious need to attract more dentists to Kansas. There is an even greater need to attract dentists who are willing to take Medicaid patients. We feel strongly that local communities and most importantly the consumer would benefit greatly from a dental practice owned and operated by highly-trained licensed dentists which embrace transparency in their pricing and maintains extended weekday and weekend hours.

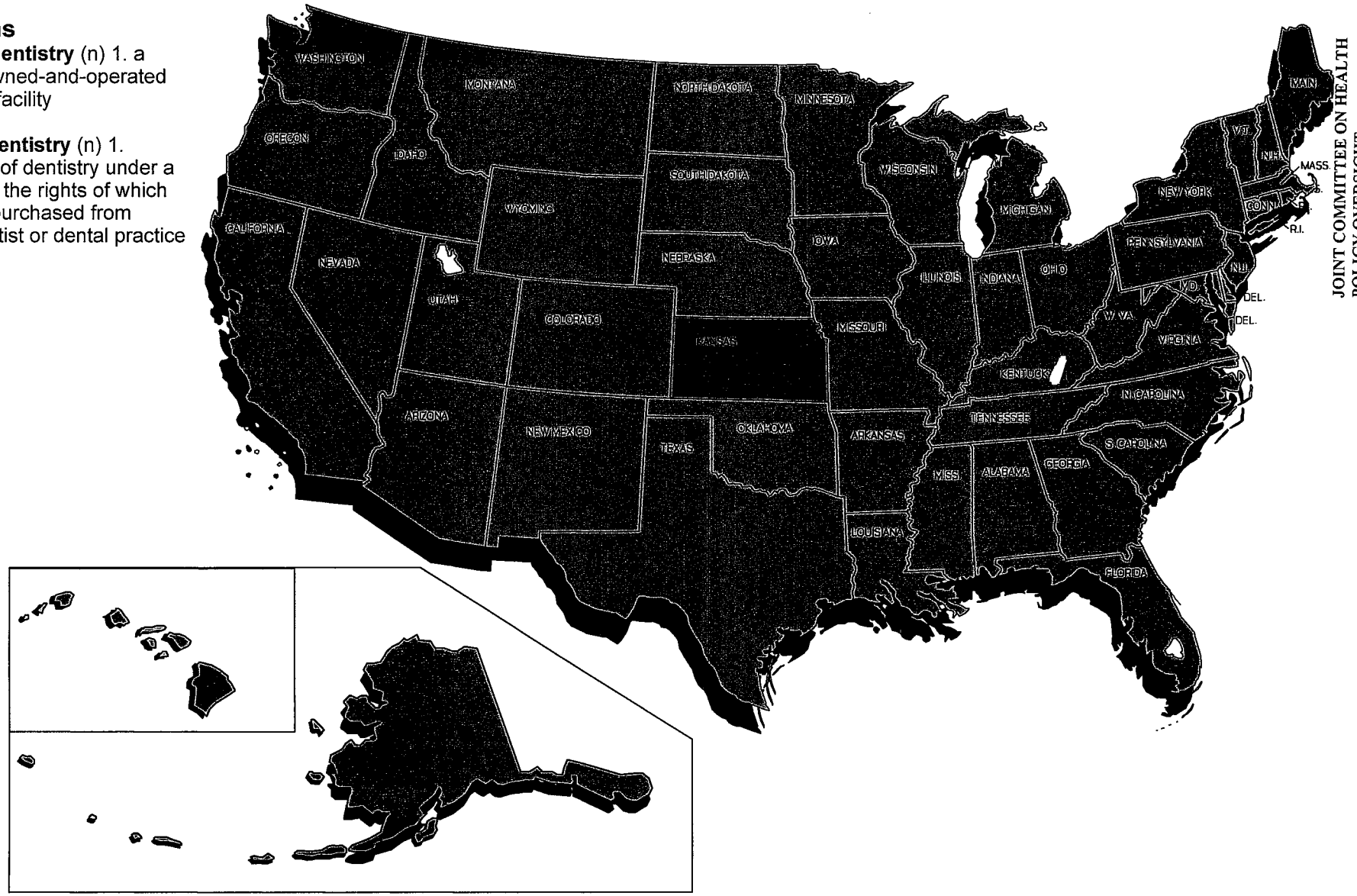
At a time when young dentists leave dental school with tremendous debt, limiting their options to own their own dental practice, a franchise ownership arrangement offers an attractive option for them that we thought would be welcomed by the dental community and the regulating agency.

I greatly appreciate the opportunity to visit briefly with you today. Comfort Dental, in the worst way, wants to be part of the solution to the very-real dental shortage issue in Kansas. I look forward to working with you in the upcoming Session. I am happy to stand for any questions you might have.

)efinitions

corporate dentistry (n) 1. a company-owned-and-operated dental care facility

franchise dentistry (n) 1. the practice of dentistry under a trade name, the rights of which have been purchased from another dentist or dental practice



Comfort Dental Franchise Locations

States That Permit Dentist Owned Franchises

States That Do Not Permit Dentist Owned Franchises

JOINT COMMITTEE ON HEALTH
POLICY OVERSIGHT
DATE: 12-2-10
ATTACHMENT: 19

List of KHPA contracts in process of negotiation Dec 2010-Jan 2011

1. Kansas Foundation for Medical Care - External Quality Review Organization (EQRO) amendment will reduce the number of review tasks to only those that required by regulation. Amendment is effective December 1, 2010 and will create anticipated all funds savings thru calendar year 2014.

2. Policy Studies Inc. - Clearinghouse amendment for enrollment in Title XIX and Title XXI programs will reinstate performance standards effective December 31, 2010. This amendment reinstates performance requirements resulting from the Governor's budget cuts issued on November 23, 2009, KHPA recognized that PSI would not be able to meet all of the performance expectations, performance standards, performance guarantees, industry standards, implied requirements, and other requirements for all areas of this Contract as stated in the Contract. This is a no cost amendment.

3. Medical Transportation Management - Non Emergency Medical Transportation (NEMT) amendment will extend the contract for one year from June 30, 2011 through June 30, 2012 and adjust the Per Member per Month (PMPM) rate for increased utilization. Cost of PMPM is currently being developed by KHPA staff.

4. Public Consulting Group – This amendment will be for one year beginning February 1, 2011 and is for School District Medicaid matching and cost settlement for Special Education Services.