MINUTES

JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT

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

Members Present

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

Staff Present

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

Conferees

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

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

Others Attending

See attached list.

Thursday, November 4
Morning Session

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The meeting recessed at noon for lunch.

Afternoon Session

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

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

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

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

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

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

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

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

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

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

Bill Sneed again addressed the Committee with the following thoughts.

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

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

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

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

Ms. Brooks wrapped up with the following challenges:

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

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

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

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

Friday, November 5
Morning Session

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

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

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

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

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

The following topics were reviewed:

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

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

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

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

Other topics included in the handout:

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

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

- Enhanced PA (Prior Authorization) System.

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

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

Objectives of the Family Nutritional Program (FNP) Include:

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

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

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

- Increase participation in physical activity.

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

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

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

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

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

Afternoon Session

The meeting reconvened at 1:17 p.m.

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

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

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

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

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

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

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

Updates were provided on the following topics:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Requirements on Maintenance of Effort (Attachment 21);

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

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

- CHIP Cost Sharing information (Attachment 24).

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

Prepared by Debbie Bartuccio
Edited by Kathie Sparks

Approved by the Committee on:

December 8, 2010
(Date)