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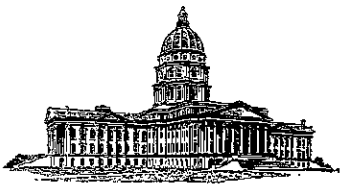

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
CHAIRMAN: VISION 2020

MEMBER: AGRICULTURE AND NATURAL RESOURCES
TRANSPORTATION

KanCare II – HB 2270

Mr. Chairman, Members of the Committee: The Vision 2020 Committee held two weeks of hearings to determine if there is a need to expand KanCare coverage and concluded that this is important to the State's healthcare and economic healths.

Expanding KanCare to cover people earning up to 138 percent of the Federal Poverty Level is essential to cost-effectively improving the health of an estimated 169,000 Kansans, 100,000 of whom are "working poor." KanCare expansion is also essential for the financial health of Rural Critical Access Hospitals, other Kansas hospitals, and health care providers. KanCare expansion is the bridge to receiving an estimated $2.2 billion in federal health care aid between 2016-2020.

The Committee then spent an additional two weeks taking testimony on what should be in a KanCare expansion plan/legislation. Our goals were four-fold: **1. Improve health care outcomes through innovative cost-effective programs with performance auditing; 2) Improve the financial health of healthcare provider organizations; 3) Propose a funding stream for the State's share of the expanded Medicaid/KanCare Program that does not involve State General Fund dollars; and 4) Do the above in a Kansas manner.** Following, in summary fashion, are the specifics of how we strove to accomplish those four objectives in ways that the Governor and Legislators can support.

Establish: Kansas Healthcare Administrative Support Fee

Tiered Fee:
- Tier # 1 – Hospitals
- Tier # 2 – Safety Net Clinics that receive federal payments
- Tier # 3 – At the Secretary's discretion, other recipients of federal and/or state health care reimbursements.

Secretary of KDHE shall establish the Kansas Healthcare Administrative Support Fees through rules and regulations based on each service provider identified above total revenue data from the Medical Assistance Report for the previous year. For guidance in establishing the fees, the Secretary shall collect no more than 5 percent more than:

$10.3 million in 2016
$68.4 million in 2017
$72.9 million in 2018
$77.6 million in 2019
$82.70 million in 2020.

The additional 5 percent will be used to cover administrative and contract fee costs.

The Secretary shall explore alternative funding options beginning with FY 2019 and make recommendations to the 2017 Kansas Legislature. Among other options, the Secretary shall consider a program similar to the Dept. of Commerce coordinated PEAK program for growth in the health care sector employment and a variant on funding for the Kansas Bioscience Authority. **

The Secretary, in conjunction with the MCOs, shall establish: a) a sliding co-pay scale based on individuals' income level. Such scale shall be based on experience in Kansas and other states to maximize patient recognition of the costs associated with treating chronic conditions and the benefits from preventive and managed care;
b) a monthly premium payment system for which participants are eligible , on the basis of a participant payment sliding scale, for KanCare subsidies to pay for private insurance policies through the Health Care Exchange; or
c) both models.

The Secretary, in cooperation with the MCOs, shall establish a statewide pilot program for direct primary care service health care delivery business model for KanCare participants. This concierge-type statewide pilot program shall provide for a monthly capitated health care provider payment rate, rather than the more prevalent coding for reimbursement model. The statewide concierge-type program shall be available to physicians, advanced practice registered nurses, physicians assistants, registered nurses, and other health care providers designated by the Secretary, whether such practices is solely based on the concierge-type model or is a component of that health care provider's regular practice. The Secretary shall establish the monthly capita subscription fee, primary services to be provided on an "including, but not limited to" basis, and such other criteria as the Secretary shall deem appropriate.

The Secretary, in cooperation with the MCOs, shall establish KanCare II reimbursement rates that recognize holistic patient centered case management and health care services by reflecting the value of regular or on-going patient health care monitoring and patient education in reducing costs associated with treating chronic conditions. Participant visits to physician offices, clinics, hospitals, or other settings shall largely be based on the health monitoring results, regular check-ups, and emergencies. This is not to mean that KanCare participants are not to see physicians, rather that the monitoring and education programs should minimize the need for such visits. Reimbursement rates shall reward monitoring of patient health through home monitoring systems and direct patient education programs overseen by a physician, physician assistant, advanced practice registered nurses or registered nurse.

The Secretary, in coordination with the MCOs, shall ensure that the frail elderly; physically disabled; aged, blind and disabled; and such other persons with chronic conditions as the Secretary shall designate are eligible for telehealth monitoring and education services with no non-medical restrictions related to geography, patient setting, provider type, or originating site. Originating site fees shall be included in the reimbursement schedule. **

The Secretary, in cooperation with the MCOs, shall establish reimbursement rates that include physician to physician specific patient directed continuing education that is conducted electronically with the patient present, when such consultations with a specialist physician otherwise would result in the patient traveling to the consulting physician's office, clinic, or hospital.

Reimbursement rates for tele-health monitoring, education, diagnosis, and other approved services shall be no less than for similar services delivered within a physician's or clinical or hospital setting. Tele-health rates may be used to incent fewer visits to higher cost service locations.

Health care outcomes data, as specified by the Secretary, for all services provided KanCare participants shall be provided quarterly to the Secretary and analyzed by the Kansas University Medical Center to identify the most successful patient treatment, monitoring, and education programs in terms of cost-effectively improving health outcomes. Such analysis to include indications of comparative health care improvement outcome benefits and cost benefits of the sliding co-pay model (indicated above), the sliding monthly insurance premium payment model (indicated above), a combination of the two above models, and the direct primary care service or concierge-type service (indicated above). KUMC analysis results to be reported quarterly to the Secretary and the KanCare Oversight Committee. The Secretary shall provide that data annually to the House and Senate Public Health Committees. The Secretary shall contract with KUMC for these analytical services using the Kansas Healthcare Administrative Support Fees.

Patient and/or family funded health care savings accounts are authorized to assist KanCare recipients meet co-pay obligations under both the sliding co-pay and sliding insurance co-pay models.

The Secretary shall seek waivers for any components of the KanCare II program that are not currently authorized in KanCare.

All programs will be offered statewide to ensure full federal participation in reimbursing health care providers.

If federal support for the program falls below 90 percent reimbursement, the State may re-evaluate continued participation.

The Secretary shall explore with MCOs the feasibility of establishing an integrated overall treatment price for specific health care delivery situations, instead of billing for each patient encounter and procedure. Such integrated prices would reflect the average cost of treating a heart attack or broken leg (for example), rather than billing for every X-ray, consultation, etc. The exploration shall focus on whether health care outcomes will be the same or better under such a program and whether reducing the incentives associated with "over testing" with the expectation that overall costs to the beneficiaries and KanCare system will be lower under such a program. The Secretary shall report her recommendations to the Legislature by January 1, 2016.

The Secretary shall explore with MCOs, private insurance companies, the Kansas Medical Society, Kansas Hospital Association, and such other health care stakeholders as the Secretary deems appropriate, ways to facilitate better coordination between urban and rural hospitals to improve medical outcomes and reduce costs. The Secretary shall report her recommendations to the Legislature by January 1, 2017.

Because HB 2319 simply authorizes the Governor to implement an expanded KanCare program, but does not provide a funding mechanism, guidance on establishing a long-term funding mechanism, auditing of innovative cost-effective ways to deliver improved healthcare outcomes, expanding the partnership with existing MCOs, or any other specifics, the Vision 2020 Committee members recommend that you amend HB 2270 into HB 2319.

Thank you for your consideration of our recommendations and deliberations. I look forward to answering your questions at the appropriate time.