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**MEMORANDUM**

To: Committee on Vision 2020  
From: Renae Jefferies, Assistant Revisor of Statutes  
Date: February 9, 2015  
Subject: HB 2270

Section 1 allows that the bill shall be known and may be cited as the KanCare II expansion act. Section 2 sets out the definitions for words used in the bill.

Section 3 provides that the secretary shall establish a tiered health care administrative support fee. The secretary by rules and regulations shall charge and collect such fees based on an amount no greater than 105% of the following annual base amounts: \$10.3 million in 2016; \$68.4 million in 2017; \$72.9 million in 2018; \$77.6 million in 2019 and \$82.7 million in 2020. Of the 105%, the 5% above the 100% shall be used to cover administrative and contract fees for verifying and evaluating program performance.

The secretary, in cooperation with the managed care organizations and health care providers, shall evaluate alternative funding options beginning with fiscal year 2019 and make recommendations to the 2017 legislature. Two such options are: (1) A program recognizing growth in health care sector employment equivalent to the Department of Commerce administered PEAK program; and (2) a program equivalent to the bioscience authority's revenue methodology.

The secretary, in conjunction with the managed care organizations, shall establish: (1) A sliding co-pay scale based on an individual's income level 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; (2) a monthly premium payment system for which beneficiaries are eligible, on the basis of a beneficiary sliding scale, for KanCare subsidies to pay for private insurance policies through the health care exchange; or both models; a statewide concierge-type pilot

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program for a direct primary care service health care delivery business model for KanCare beneficiaries; and 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. Beneficiary visits to physician offices, clinics, hospitals or other settings shall largely be based on the health monitoring results, regular check-ups and emergencies.

The secretary, in cooperation with the managed care organizations, shall: Ensure that frail elderly, physically disabled, aged, blind and disabled and other persons with chronic conditions as the secretary shall designate are eligible for tele-health monitoring and education services; and establish reimbursement rates that include physician-to-physician specific patient-directed continuing education that is conducted electronically with the patient present in order to save a patient from traveling a large distance to see a specialist. Reimbursement rates for tele-health monitoring, education, diagnosis and other approved services shall be no less than that for similar services delivered within a physician's office or clinical or hospital setting.

Section 4 provides that the health care outcomes data, as specified by the secretary, for all services provided to KanCare II beneficiaries 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-effectiveness in improving health outcomes. Such analysis shall include indications of comparative health care improvement outcome benefits and cost benefits of the sliding co-pay model, the sliding monthly insurance premium payment model, a combination of the two models and the direct primary care service or concierge-type service. The Kansas university medical center's analysis results shall be reported quarterly to the secretary and the Robert G. (Bob) Bethell joint committee on home and community based services and KanCare oversight and annually to the house committee on Health and Human Services and Senate committee on Public Health and Welfare.

Section 5 provides that patient-funded or family-funded health savings accounts, or both, as defined in 26 U.S.C. section 233(d) are authorized to assist KanCare II beneficiaries in meeting co-pay obligations.

Section 6 provides that the secretary shall seek waivers for any components of KanCare II that are not authorized under the current KanCare program. All programs

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under KanCare II shall be offered statewide to ensure full federal participation in reimbursing health care providers. However, if the federal reimbursement rate under KanCare II costs drops below 90%, the state may re-evaluate the continuation of this act.

Section 7 provides that the secretary along with the managed care organizations shall explore the feasibility of establishing an integrated overall treatment price for specific health care delivery situations, instead of billing each patient encounter and procedure. Additionally, the secretary along with the managed care organizations, private insurance companies, the Kansas Medical Society, Kansas Hospital Association and other health care stakeholders as the secretary deems appropriate shall explore ways to facilitate better coordination between urban and rural hospitals to improve medical outcomes and reduce costs.

Section 8 provides that the secretary may require a work component for able-bodied beneficiaries under KanCare II. Such work may be a paid or volunteer position.

Section 9 establishes the Kansas health care administrative support fee fund in the state treasury. Such fund will be administered by the Department of Health and Environment. All expenditures from such fund shall be in support of KanCare II upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the secretary or the secretary's designee.

Section 10 provides that the secretary by rules and regulations shall implement the provisions of this act.

Section 11 amends K.S.A. 39-709(e)(2), and amendments thereto, to provide that on or after January 1, 2016, medical assistance shall be granted to any adult under 65 years of age, not pregnant and whose income does not exceed 138% of the federal poverty level.

Should the bill pass both houses and be signed into law by the governor, the act would become effective upon publication in the statute book.