Approved: 03/08/10
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman Jim Barnett at 1:30 p.m. on January 28, 2010, in Room 546-S of the Capitol.

All members were present.

Committee staff present:
Nobuko Folmsbee, Office of the Revisor of Statutes
Renae Jefferies, Office of the Revisor of Statutes
Iraida Orr, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Jan Lunn, Committee Assistant

Conferees appearing before the Committee:
Roderick Bremby, Secretary, Kansas Department of Health and Environment
Jason Eberhart-Phillips, MD, MPH, Director of Health and State Health Officer
Dr. Andrew Allison, acting interim Executive Director, Kansas Health Policy Authority

Others attending:
See attached list.

Chairman Barnett introduced Ken Wright, MD, from Emporia, who was attending the meeting while serving as the Legislative "Doctor of the Day."

Jerry Slaughter, Director, Kansas Medical Society, requested introduction of a bill that would allow the use of the word doctor (MD), doctor of osteopathic medicine (DO), or a doctor of chiropractic medicine (DC) by unlicensed individuals if he or she earned a professional degree from an accredited healing arts school or college and the use of the word or initials is not misleading to the public, patients, or other healthcare providers.

Senator Kelsey moved introduction; Senator Huntington seconded the motion which passed.

Kathleen Lippert, acting Executive Director of the Kansas Board of Healing Arts, requested introduction of three bills:

1.) A bill amending current law concerning the dispensing of contact lenses in Kansas and broadening the definition of "mail" to include the use of a commercial courier or overnight or other delivery services.
2.) A bill amending current law concerning the licensure of physical therapists by creating two new licensure categories "exempt license" and "federally active license."
3.) A bill amending current law to permit respiratory therapy graduates to retain the special permit issued to them as students for a defined period which would allow the graduate to complete licensure requirements.

Upon a motion by Senator Schmidt and a second by Senator Colyer to move introduction of the three bills presented by Ms. Lippert; the motion passed.

Senator Kelsey moved introduction of a bill concerning licensure and education of perfusionists; Senator Schmidt seconded the motion which passed.

Tracy Russell, on behalf of the Kansas Health Consumer Coalition, requested introduction of a bill that limits charges for hospital goods and services for self-pay patients equal to those charged to patients with group health insurance

Upon a motion by Senator Kelly and a second by Second Huntington to move introduction, the motion passed.

Kansas Department of Health and Environment (KDHE) - Agency Overview and the State of Health in Kansas

Secretary Bremby discussed the accomplishments, mission, and organization of the

Department of Health and Environment (Attachment 1). Secretary Bremby focused on accomplishments within the last year.

Dr. Jason Eberhart-Phillips was recognized to provide his assessment regarding the state of health in Kansas. Dr. Eberhart-Phillips spoke about the vision of health which focuses on the top two health challenges: tobacco and obesity (see information included in Attachment 1). He closed his comments by indicating KDHE and healthcare partners cannot create a healthy Kansas with programs alone; it takes individuals from the private sector, schools, local government, and faith-based organizations collaborating to positively impact health in Kansas.

Dr. Andrew Allison, Kansas Health Policy Authority (KHPA), provided an overview of the FY 2009 budget indicating KHPA operations and caseload costs (Medicaid) are funded separately (Attachment 2). He reported that until 2010, budget reductions were concentrated on operations. However, in November 2009, the Governor's state general fund (SGF) allotments affected caseload reductions (Medicaid), operations (administration reductions), and SCHIP funding. Detailed discussion on these reductions followed. Further discussion was heard on optional services and optional population spending in Kansas Medicaid.

Dr. Allison provided follow-up to questions heard at the January 14, 2010 meeting. He described how upper dosage limits are set, the Lock-In program and the SURS review process, the Beneficiary Peer Group Comparison Report, the Multiple Pharmacies Report, and the Multiple Prescribers Report. In addition, Dr. Allison indicated KHPA plans to investigate further into the role that non-participating prescribers might have in supporting the misuse of controlled substances in the Medicaid program. System changes also will be reviewed to evaluate the feasibility of limiting reimbursement for prescriptions written by non-participating providers as well as the impact on the beneficiary's access to care (Attachment 3).

Approval of Minutes

The minutes of the January 13, 2010 meeting were reviewed. Upon a motion by Senator Brungardt and a second by Senator Colyer to approve the minutes as submitted, the motion passed.

Senator Barnett adjourned the meeting at 2:32 p.m.

PUBLIC HEALTH AND WELFARE
GUEST LIST
January 28, 2010

NAME	AFFILIATION
Dan Morin	KS Medical Society
Chad Austin	KHA
Pat Hubbell	Phrma
Cynthia Smith	SCL Health Systems
Bud Burke	Lilly / PT's
Nodie Wellshear	Ks Academy of Family Physicians
Susan Kang	KDHE
Rod Bremby	KDHE
Jason Eberhart-Phillips	KDHE
[illegible]	KHMA
Andy Allison	KHPA
Brad Sampson	KHPA
LeAnn Bell	KHPA
Dustin Moyer	KHPA
Bob Williams	Ks Assoc Osteopathic Medicine
Lynn Ratz	LPA
Stephen Koranda	KS Public Radio
Leigh Keck	Hein Law Firm
Taylor Soucaman	~~Kansa~~
Craig Gunther	KS State Nurses Assoc
Julia Mowers	KSBHA
Kathleen Selzler Lippert	KSBHA
Marlee Carpenter	KAHP
Christina Morris	KBOP

Debra Billingsley — KBOP

Chad M. Moore — Children's Mercy Family Health Partners

Suzanne Wikle — KS Action for Children

Patrick J. Hurley — [illegible]

Michelle Butler — Capitol Strategies

[illegible] — Ks Optometric Assoc

Ken Wright MS
Mike Hammond
Nancy Zogleman
Barbara Belcher
Robin Clements
Anne Spiess
Tracy Russell
Mike Shields
[illegible]

Physician - Doc of day
Assoc. of CMHCs of KS
Polsinelli
Merck
DCCCA
American Cancer Society
KHCC
KHI News
United Health Group

KDHE Overview & 2009 Accomplishments

Roderick L. Bremby, Secretary
Kansas Department of
Health & Environment
January, 2010

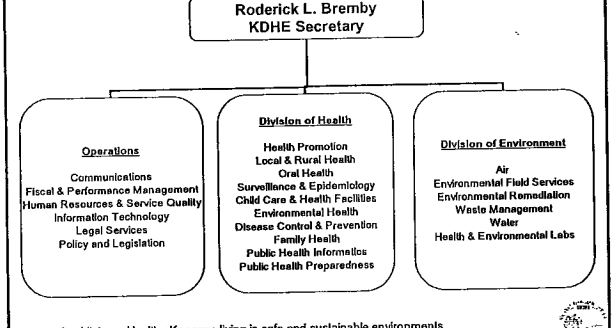
The Kansas Department of Health and Environment

Our Vision
Healthy Kansans living in safe and sustainable environments

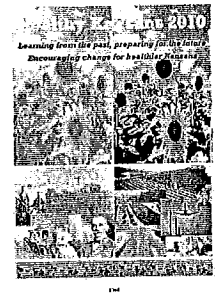
Our Mission
To protect the health and environment of all Kansans by promoting responsible choices

Our Values
- Leadership
- Accountability
- Communication
- Integrity
- Teamwork

KDHE Organization Chart



State of the State - Health



Public Health and Welfare
Date: 1/28/10
Attachment: 1

KDHE Division of Health

- Bureau of Health Promotion
- Bureau of Local & Rural Health
- Bureau of Oral Health
- Bureau of Surveillance & Epidemiology
- Bureau of Child Care & Health Facilities
- Bureau of Environmental Health
- Bureau of Disease Control & Prevention
- Bureau of Family Health
- Bureau of Public Health Informatics
- Bureau for Public Health Preparedness

KDHE Division of Health

KDHE's Division of Health is responsible for:

- Licensing and regulating day cares, preschools, foster homes, residential centers, hospitals and treatment facilities
- Credentialing health care workers

KDHE Division of Health

- Investigating disease outbreaks and helping to prevent the spread of disease by promoting healthy behavior and immunizations
- Educating the public about chronic diseases and injury prevention

KDHE Division of Health

- Assisting Kansas communities in establishing systems to provide public health, primary care and prevention services
- Addressing the special needs of children through infant screening programs, nutrition programs and services for children with special health needs

KDHE Division of Health

- Managing the civil registration system for the state by collecting and processing records on births, deaths, marriages and divorces, and providing reliable statistics to policymakers, program managers and the public

2009 Division of Health Happenings & Accomplishments

- Several agency programs worked on the state's H1N1 response, for example:
  - Developed and implemented a comprehensive surveillance system
  - Managed vaccine allocation, ordering and distribution of nearly 800,000 doses of vaccine in first 2 ½ availability
  - Set up a hotline, developed educational materials and web pages to provide information to a number of target audiences

2009 Division of Health Happenings & Accomplishments

- Facilitated the donation of over $1.1 million in medications to uninsured, low-income Kansans through the newly created Unused Medications Clearinghouse .
- Completed the 2009 Oral Health Workforce Assessment, a comprehensive survey of Kansas dentists and dental hygienists with Extended Care Permits.

2009 Division of Health Happenings & Accomplishments

- Established the Bureau of Environmental Health to combine the activities of the Healthy Homes and Lead Hazard Prevention Program, the Radiation and Asbestos Control Section, and the newly established Environmental Public Health Tracking Program.

2009 Division of Health Happenings & Accomplishments

- Continued success of KSWebIZ, the statewide immunization registry
  - More than 1.6 million patients enrolled
  - 44 new immunization provider sites enrolled – totaling 244 provider practices
  - KSWebIZ school module has been accessed by 312 schools in 76 school districts
  - Added a module to manage H1N1 vaccine inventory and assist local health departments with dose documentation.

2009 Division of Health Happenings & Accomplishments

- The Health Facilities program implemented a customer satisfaction survey so that providers can assess surveyor performance. The survey was recognized by the Association of Health Facility State Survey Agencies at its annual conference.

2009 Division of Health Happenings & Accomplishments

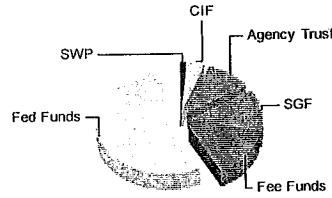
- The TB Prevention and Control Program worked with colleges and universities to advance TB screening programs of higher-risk individuals using a new blood test. All major universities began using this test and saw a dramatic decrease in the resources required to conduct screening, saving fiscal resources for the universities.

2009 Division of Health Happenings & Accomplishments

- The Kansas WIC Program
  - Implemented new food package guidelines emphasizing lower-fat milk, whole-grain breads and cereals, fruits and vegetables, baby food fruits and vegetables, beans, and more varieties of canned fish.
  - On average, served more than 79,150 women, infants and children per month. That's more than 6,550 more participants per month than last year.

Budget:
2011 Governor Recommendations

Budget by Fund Classification

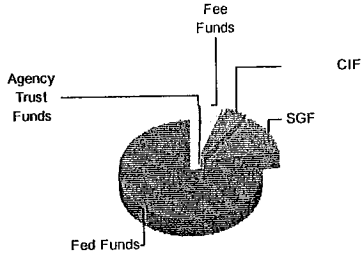


SWP	$3,045,459	1.3%
CIF	$9,294,766	3.9%
Agency Trust Funds	$25,042,090	10.5%
SGF	$31,076,171	13.1%
Fee Funds	$32,231,192	13.6%
Fed Funds	$136,711,755	57.6%
Total:	$237,401,433	100.0%

Our Vision – Healthy Kansans living in safe and sustainable environments

Budget:
2011 Health Division

Budget by Fund Classification

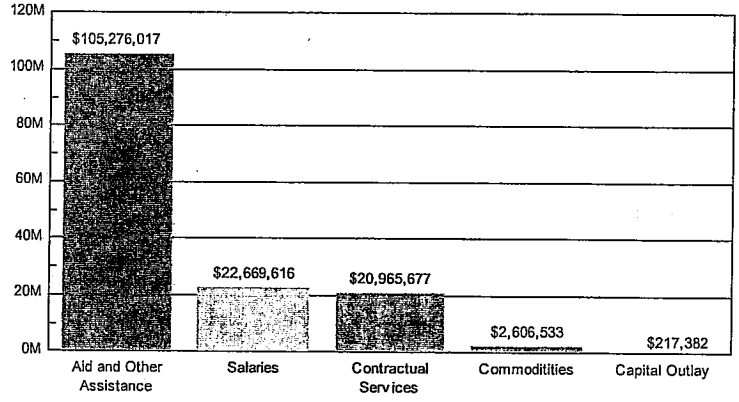


Agency Trust Funds	$785,733	0.5%
Fee Funds	$7,105,501	4.7%
CIF	$7,393,703	4.9%
SGF	$19,435,453	12.8%
Fed Funds	$117,014,835	77.1%
Total:	$151,735,225	100.0%

Our Vision – Healthy Kansans living in safe and sustainable environments

Budget:
2010 Health Division

Budget by Expenditure Type



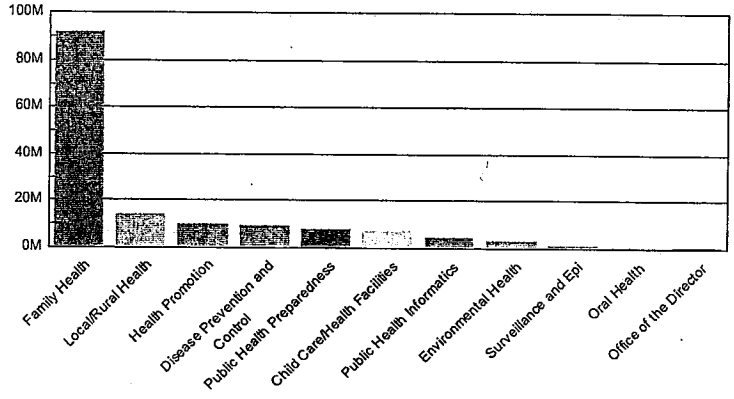
Total Health Budget: $

Our Vision – Healthy Kansans living in safe and sustainable environments

19

Budget:
2011 Health Budget

Budget by Program



Total Health Budget: $151,735,225

Our Vision – Healthy Kansans living in safe and sustainable environments

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KDHE Division of Environment

- Bureau of Air
- Bureau of Environmental Field Services
- Bureau of Environmental Remediation
- Bureau of Waste Management
- Bureau of Water
- Kansas Health & Environmental Laboratories

Division of Environment

KDHE's Division of Environment is responsible for:

- Conducting regulatory programs for public water supplies, industrial discharges, wastewater treatment systems, solid waste landfills, hazardous waste, air emissions, radioactive materials, asbestos removal, refined petroleum storage tanks and others

Division of Environment

- Administering programs to remediate contamination and evaluate environmental conditions across the state
- Ensuring compliance with federal and state environmental laws

Division of Environment

- Working with the Environmental Protection Agency to preserve the state's natural resources
- Providing laboratory data in support of public health and certifying the quality of Kansas laboratories

Division of Environment

- Providing scientific analysis to help diagnose and prevent diseases
- Providing laboratory test results to help guard public drinking water, ambient air and surface/ground water quality

2009 Division of Environment Happenings & Accomplishments

- **Bureau of Air was awarded $4 million by the EPA to reduce diesel fleet emissions in Kansas. The bureau also received an additional $1.73 million to reissue the Kansas Clean Diesel Program grant competition in 2009 for public and private fleet owners and operators across the state.**

2009 Division of Environment Happenings & Accomplishments

- **Made 33 low-interest state revolving loans for $71 million for 30 municipal water quality projects across the state. Of this total, $48 million was for 14 wastewater infrastructure projects, with another $23 million going to 16 public water supply projects.**

2009 Division of Environment Happenings & Accomplishments

- **Worked with Siemens Energy to locate a $50 million wind turbine manufacturing facility in Hutchinson. Estimates are that the factory will employ 400 Kansans.**

2009 Division of Environment Happenings & Accomplishments

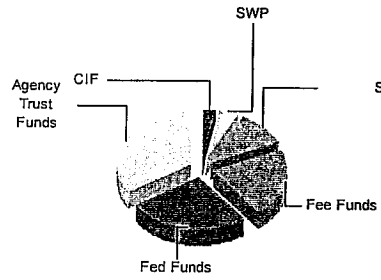
- Six regional e-waste collection centers became fully operational in 2009 and expanded service to about 70 counties. These centers received capital improvement grants from the solid waste program.

2009 Division of Environment Happenings & Accomplishments

- The Kansas Health and Environmental Laboratories provided training for those collecting blood spots for the newborn screening program. This training helped to reduce the number of unsatisfactory specimens from a monthly high of 14 percent in March 2008 to a monthly average of three percent over the last several months.

Budget:
2011 Environment Budget

Budget by Fund Classification



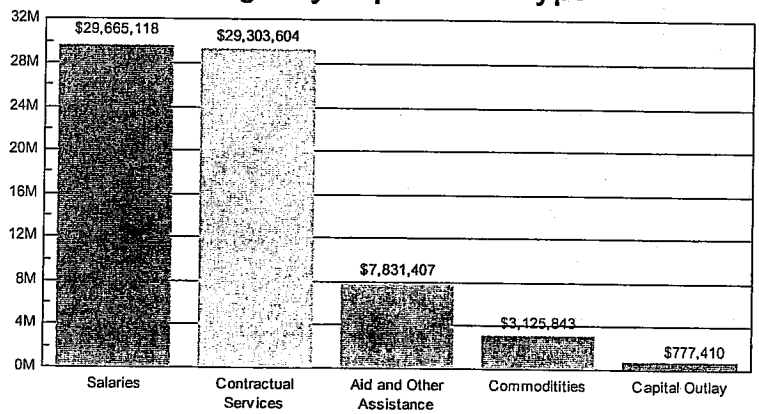
CIF	$1,898,457	2.7%
SWP	$3,045,459	4.3%
SGF	$7,779,768	11.0%
Fee Funds	$15,140,627	21.4%
Fed Funds	$18,615,087	26.3%
Agency Trust Funds	$24,223,984	34.3%
Total:	$70,703,382	100.0%

Total Environment Budget: $70,703,382

Our Vision – Healthy Kansans living in safe and sustainable environments

Budget:
2011 Environment Budget

Budget by Expenditure Type

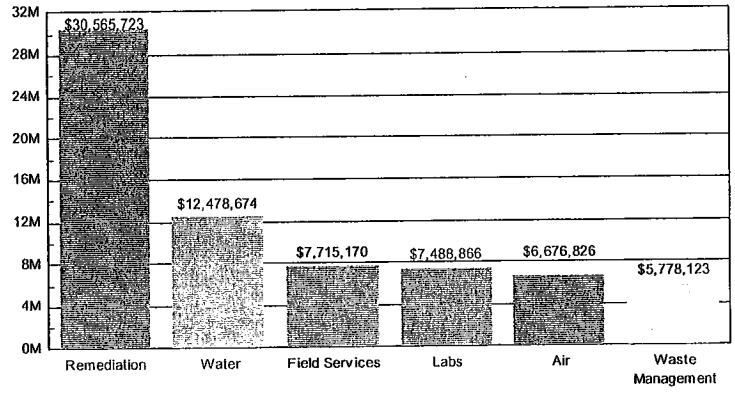


Total Environment Budget: $70,703,382

Our Vision – Healthy Kansans living in safe and sustainable environments

Budget:
2011 Environment Budget

Budget by Program

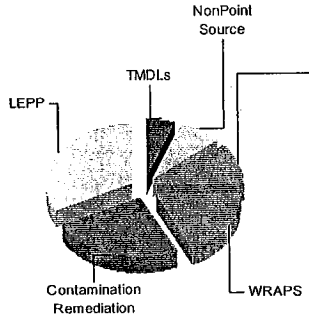


Total Environment Budget: $70,703,382

Our Vision – Healthy Kansans living in safe and sustainable environments

Budget:
2011 Environment Budget

State Water Plan Budget by Program



TMDLs	$166,821	5.5%
NonPoint Source	$246,072	8.1%
Treece Match	$350,000	11.5%
WRAPS	$548,696	18.0%
Contamination Remediation	$753,870	24.8%
LEPP	$980,000	32.2%
Total:	$3,045,459	100.0%

Total SWP Budget : $3,045,459

Our Vision – Healthy Kansans living in safe and sustainable environments

Budget:
2011 Environment Division

- Approximately $2.1M of State Water Plan Funds is for match to leverage federal or other funds.

A Vision of Health

The 2010 Legislative Agenda
Division of Health, KDHE

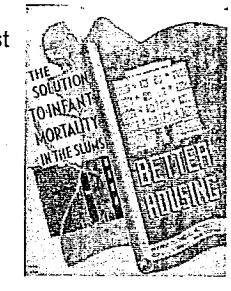
Jason Eberhart-Phillips, MD, MPH
Director of Health and
State Health Officer

What is Public Health?

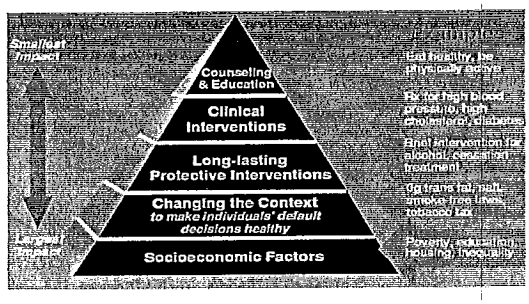
- Public health is the science and art of preventing disease, prolonging life and promoting health through the organized efforts of society
- Collective action for the common good

It's Forward-Looking

- It is about changing the conditions at the root of most diseases
- Public health aims to create environments where all people can enjoy optimal health
  - Physical environments
  - Social environments
- 'Upstream' thinking



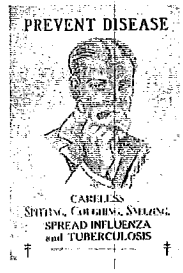
Factors That Affect Health



Our Vision – Healthy Kansans living in safe and sustainable environments

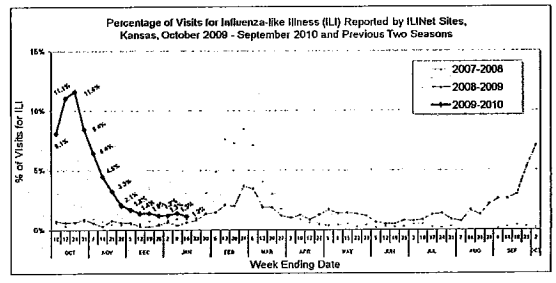
H1N1 Flu Update

- Global emergence of an entirely new flu virus
- By sheer luck this virus is not usually a killer
  - 100 times less lethal than the 1918 flu virus
- Still, by mid-November
  - 47 million cases in US
  - 213,000 hospitalizations
  - Almost 10,000 deaths



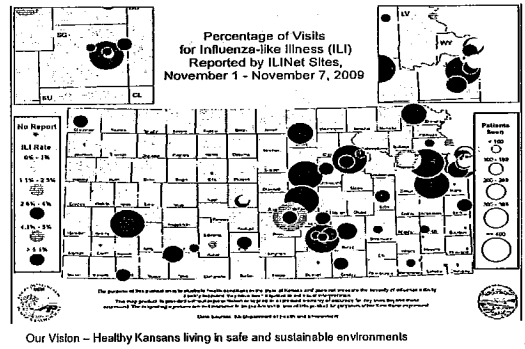
Our Vision – Healthy Kansans living in safe and sustainable environments

The "Second Wave" is Over



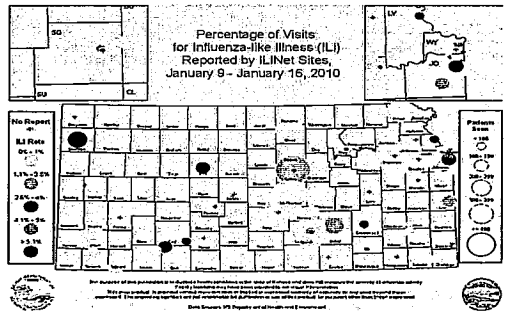
Our Vision – Healthy Kansans living in safe and sustainable environments

Where We Were at the Peak



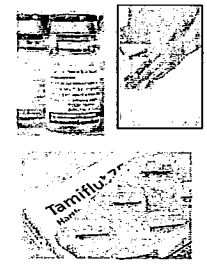
Our Vision – Healthy Kansans living in safe and sustainable environments

Where We Are Now

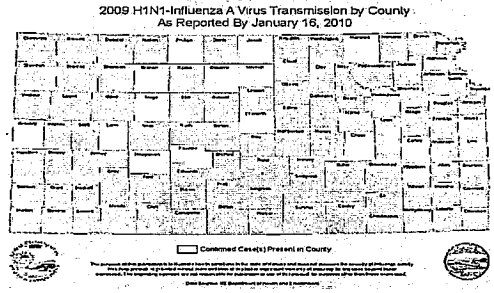


Controlling the Pandemic

- A 3-step approach
  - Vaccination, which is safe and effective
  - Non-pharmacologic measures such as covering coughs, washing hands often, and staying home if ill
  - Correct use of antiviral drugs, if prescribed



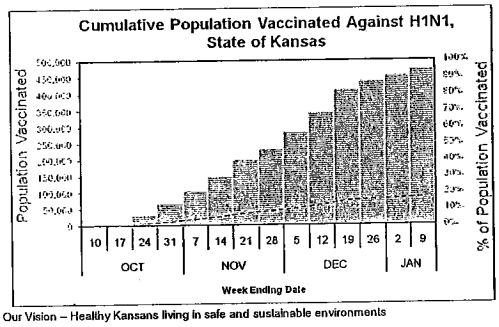
Nearly Every Place Touched



Vaccine: A Huge Success

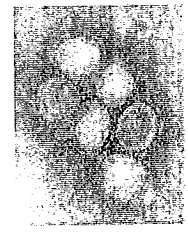
- In just over 3 months >887,000 vaccine doses have been distributed!
  - An unprecedented statewide mobilization
  - Every county health department in the lead
  - >1000 private providers
  - 1000s of volunteers staffing public clinics

Documented Vaccine Coverage



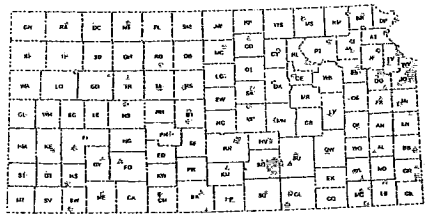
What's Next?

- Pandemic behavior is never predictable
  - They tend to occur in 'waves' of 6-12 wks
  - Roughly half of the KS population is still susceptible to H1N1
  - Window of opportunity now for vaccine before a possible 'third wave' comes this winter



Antivirals for All in Need

Voluntary network of hospitals, pharmacies and clinics making flu-fighting medications available at little or no cost from stockpile



A Communication Challenge

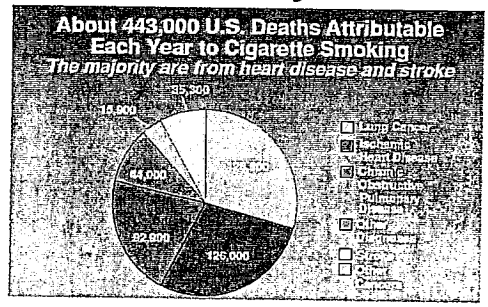
- Overcoming obstacles to flu immunization
  - Communicating the real risks from infection
  - Being clear that the vaccine is much safer than getting the disease
  - Serious harm from the vaccine is extremely rare, if it occurs at all
  - Supply is now ample!

Our Top 2 Health Challenges

- Tobacco
  - Kills at least 3,900 Kansans each year
  - Costs KS $927M/yr (direct medical costs)

- Obesity
  - Rapidly becoming the leading cause of chronic illness/death
  - Accounts for >10% of all KS Medicaid costs

It's 9/11 Every Year x 200



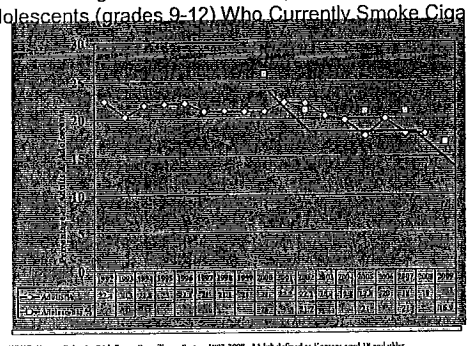
The Human Toll of Tobacco

- Linked to 25 major diseases, including
  - Cancer: Lung, throat, mouth, bladder, cervix
  - Chronic obstructive pulmonary diseases (COPD)
  - Cardiovascular disease: heart disease, stroke, congestive heart failure, aortic aneurysm
  - Peptic ulcer disease, decreased wound healing
  - Lower fertility, poor pregnancy outcomes, SIDS
- Ultimately, half of all smokers will die early due to tobacco-related causes
  - An average 15 years of life lost per smoker

The Economic Toll

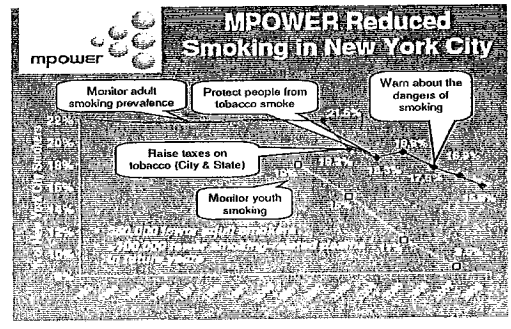
- $1.9 billion in KS/year
  - Half in medical costs
  - Half in productivity loss
  - $2,200/year per smoker
- Lifetime cost for a 24-year-old smoker:
  - Male: $220,000
  - Female: $106,000
  - Actual cost per pack of cigarettes sold: $40

Percentage of Kansas Adults (18 years & older) and Adolescents (grades 9-12) Who Currently Smoke Cigarettes



Adult Source: KDHE, Kansas Behavior Risk Factor Surveillance System 1992-2008. *Adult defined as Kansans aged 18 and older
Adolescent Source: 2000 & 2002 KDHE, Youth Tobacco Survey Grades 9-12, 2005, 2007& 2009 Kansas Coordinated School Health, Youth Risk Behavior Survey
Grades 9-12. *Adolescent defined as those in grades 9-12

NYC: Proof That it Works



Changing the Context: Tobacco

- What works
  - Counter-marketing
  - Restricting access to tobacco by minors
  - Raising prices
  - Smoke-free policies
- When these measures are wholeheartedly supported, tobacco use is greatly reduced

Raising the Tobacco Tax

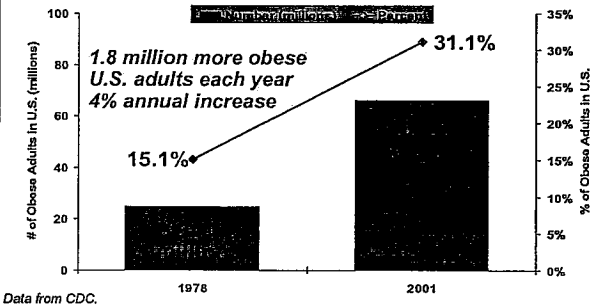
An Initiative Led by the Governor with KDHE Support

- Nearly 3,000 KS kids become addicted to smoking each year
- Increased prices cut initiation
  - Each 10% hike in price reduces the youth smoking rate by 6-7%
  - Greatest deterrent among poor
- A 55¢ per pack increase would
  - Prevent >11,000 KS kids from ever starting to smoke
  - Cause >6,000 KS adults to quit

Clean Indoor Air

- Back from 2009
- No debate: Second-hand smoke is bad:
  - Kills 400 Kansans/yr
  - Causes >2,100 KS heart attacks/yr
  - Linked to asthma, ear infections, SIDS
- CIA linked to 40% less youth smoking

An Epidemic of Obesity

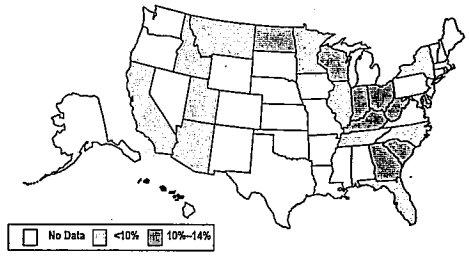


Data from CDC.

Secondhand Smoke is Costly

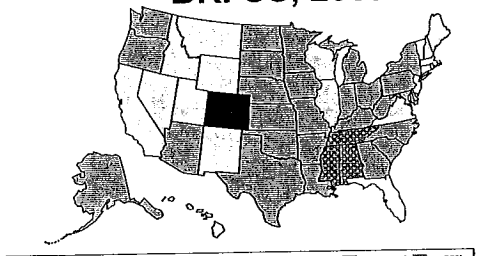
- Compelling new evidence:
  - Secondhand smoke exposure increases risk of heart attacks by 25-30%
  - Risk increased even at the lowest, briefest exposures
- CIA is good for economy
  - If it only prevents 100 KS heart attacks/yr, that saves $5 million in medical costs

Obesity Trends Among U.S. Adults BRFSS, 1985



(Obesity = BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)

Obesity Trends Among U.S. Adults BRFSS, 2007

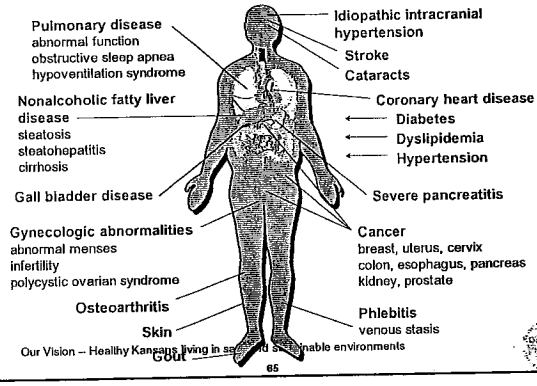


(Obesity = BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)

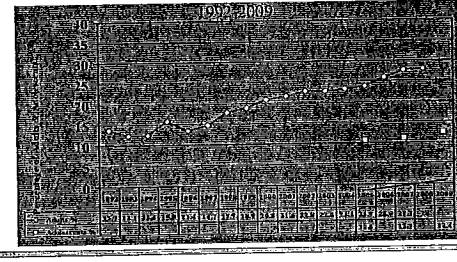
Childhood Obesity

- Obesity among U.S. kids is rapidly increasing
  - Since 1980 child obesity has more than tripled
  - 25 million kids (32%) are now obese or overweight, meaning ≥85th percentile on growth charts
  - May be first generation ever to die younger than their parents

Obesity: Medical Complications



Percentage of Kansas Adults (18 years & older) and Adolescents (grades 9-12) who are Obese

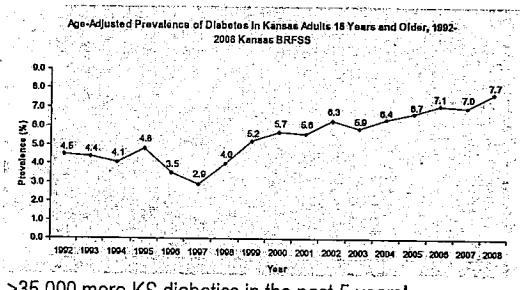


Adult Source: KDHE, Kansas Behavior Risk Factor Surveillance System 1992-2008 Obesity among adults defined as body mass index (BMI) ≥ 30
Adolescent Source: 2003, 2007 & 2009 Kansas Coordinated School Health, Youth Risk Behavior Survey - Overweight (obesity) among adolescents defined as >= 95th percentile for BMI, by age and sex
*Adult defined as Kansans aged 18 and older *Adolescent defined as those in grades 9-12

Kansas' High School Kids

- 25% of 9th to 12th graders are overweight or obese
- 79% don't get ≥5 servings of fruits or vegetables/day
- 33% have consumed ≥1 can or bottle of soda daily for the past seven days
- 55% don't get an hour of physical activity at least five times per week
- 26% watch TV for ≥3hrs/day

The Diabetes Time Bomb



>35,000 more KS diabetics in the past 5 years!

Failure Isn't an Option

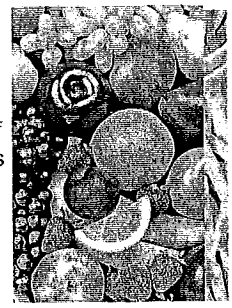
- Obese kids may have
  - Low self-esteem, poor academic performance
  - More likely to develop high blood pressure, diabetes, liver disease, sleep apnea as adults
  - 60% already have a cardiovascular risk factor; 25% have two
- Early mortality likely

The Cost of Diabetes

- $174 billion/yr is lost on medical treatment alone
  - Up 32% in just six years
  - $11,744/yr per diabetic
- Amounts to a 'tax' on every Kansan of $566/yr
- Could cut new diabetes cases in Kansas by 60%
  - If every overweight adult could lose 10-20 pounds

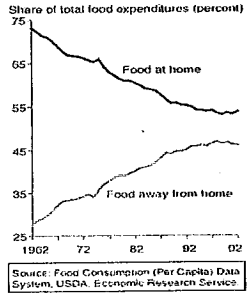
Changing the Context: Obesity

- What may work:
  - Increasing exposure to healthy foods
  - Limiting consumption of sugar-sweetened drinks and other 'junk' foods
  - Pricing adjustments
  - Modifying the 'built environment' to enable more physical activity



People are Eating Out More

- 34% of total calories by 1995, compared to 18% in 1978
- Children eat almost twice as many calories in restaurant meals compared to meals eaten at home
  - 770 vs. 420 calories



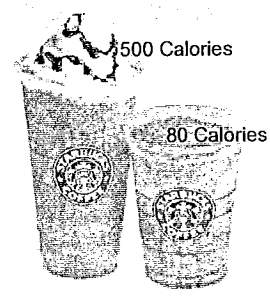
Fast Food Calories Have Risen

1977-1978	1994-1996
419	497
171	284
131	191
721	972

Increase of 251 calories (35%)

Calories Are Hard to Judge

- Restaurant foods vary widely in nutritional quality
- Most people cannot guess caloric content
- There is a tendency to underestimate
  - Even dietary experts are unable to judge calories accurately



Dietitians' estimates of the calorie content of popular restaurant foods

Food item	*average calorie estimate*	*actual calorie content*	*percent difference*
Whole milk (1 c)	155	150	3% over
Lasagna (2 c)	695	960	28% under
Grilled chicken Caesar salad with dressing (4)	440	660	33% under
Porterhouse steak dinner*	1,240	1,860	33% under
Hamburger (10 oz.) and onion rings (11 rings)	865	1,550	44% under
Tuna salad sandwich (11 oz.)	375	720	48% under

*The dinner included a Porterhouse steak (untrimmed, 20 oz. before cooking) with a Caesar salad (2 cups), vegetable of the day (1 cup) and a baked potato with butter (1 tablespoon).

How About Menu Labeling?

- Nutrition Labeling and Education Act
  - Federal law, 1990
  - Applies to most store-bought foods
  - Standardized format, clearly listing key nutritional indicators
- Why not for foods eaten outside of home too?

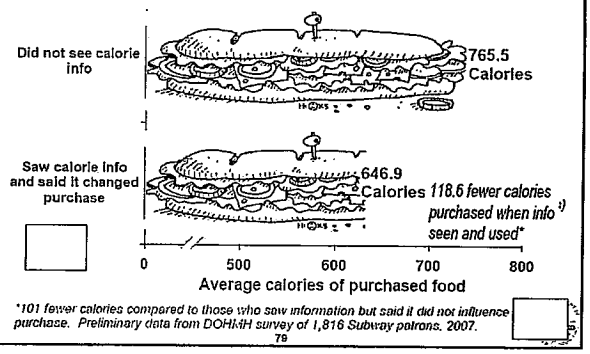
Nutrition Facts
Serving Size 1 Bar (60g)
Servings Per Container 6

Amount Per Serving	
Calories 160	Calories from Fat 70
	% Daily Value*
Total Fat 8g	12%
Saturated Fat 5g	25%
Trans Fat 0g	
Cholesterol 5mg	2%
Sodium 45mg	2%
Total Carbohydrate 21g	7%
Dietary Fiber 3g	12%
Sugars 15g	
Protein 3g	
Vitamin A 4% •	Vitamin C 0%
Calcium 10% •	Iron 0%

Evidence that Labeling Works

- Just released 12/09
  - When calories are listed, diners order items with ~14% fewer calories
  - Lost calories aren't replaced later in day
  - Confirms earlier studies in New York after 1st law passed

Calorie Information Makes a Difference in Amount People Eat



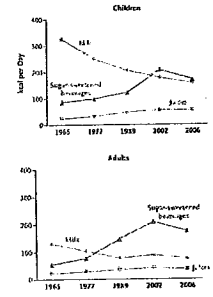
*101 fewer calories compared to those who saw information but said it did not influence purchase. Preliminary data from DOHMH survey of 1,816 Subway patrons, 2007.

Simple Policy, Huge Impact

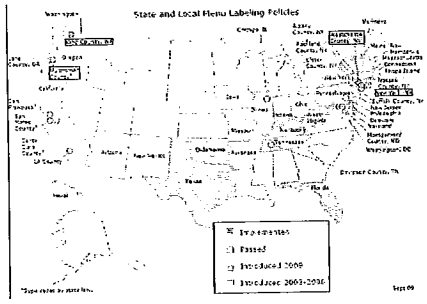
- Estimate from LA
  - If only 10% of fast-food patrons lowered their calorie intake by just 100 calories:
  - 38.7% of the county's annual weight gain would be prevented
- 10,000 new cases of diabetes prevented in Kansas in next 5 yrs

Alarming Dietary Trends

- Soft drink consumption has risen 500 percent since 1960
- Teenagers drink twice as much soda as milk
  - Only 14% of girls get enough calcium to avoid osteoporosis later in life
- Junk foods are easiest to find, most promoted

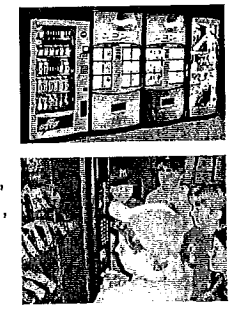


Kansas Wouldn't be Alone



What Our Kids Eat in Schools

- Cafeteria meals must meet strict federal nutrition standards
  - 'Competitive foods' sold in schools do not
  - Most are low in nutrients, high in fat, added sugars, sodium and calories
  - Typical foods are sodas, salty snacks, high-fat baked goods and candy



A Dietary 'Wild West'

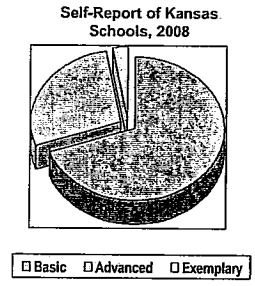
- Federal regulation of such competitive foods is extremely limited
  - Unless states or localities specify otherwise, these junk foods may be sold anywhere outside of food service areas at any time
  - KS is one of 20 states with no guidelines on the sale of competitive foods

Healthier School Eating

- KS kids deserve better
  - Limits on when and where junk food can be sold on school property
  - Rules for more nutritious items when competitive foods are sold in schools
- Sends kids a consistent message about proper nutrition for healthy living

What We Could Do

- Require all KS school districts to meet an "exemplary" standard for vending policies
  - Now only 3% do
  - No FMNV in schools
  - Strict criteria for fat, sugar and calories
  - Limit beverages to water, milk, 100% juice

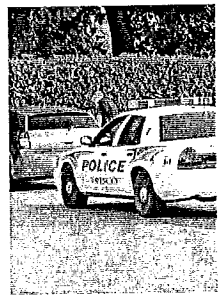


Other New KDHE Initiatives

- Licensure of audiologists
  - Increase minimum educational standard from a master's degree to doctorate in audiology
- Criminal background checks for new vital statistics employees
  - Increases protection from identity theft and fraud

Unfinished Business from 2009

- Primary Seat Belt Law (SB 59)
  - Allows police to stop a vehicle for violations of safety belt laws only
  - Would increase belt use by about 9.2 percent, up from 77 percent today
  - Would save 25 KS lives, prevent 262 serious injuries, save $70M/year



Unfinished Business from 2009

- TB evaluation requirements for postsecondary institutions (SB 62)
  - New legal requirements for colleges to prevent spread of TB; made it to conference committee
- Perinatal HIV Prevention Act (SB 147)
  - Requires providers to screen pregnant women for HIV infection, unless they opt out of testing
  - 4,000 pregnant women in KS not now screened
  - If treatment is begun during pregnancy the rate of transmission can be cut from 25% to ≤ 2%

And Three Child Care Bills

- Realign administrative sanctions available to KDHE to enforce childcare regulations (HB 2220)
  - Would allow a facility to stay open, but with restrictions, if cited for certain violations

And Three Child Care Bills

- Increasing public access to child care information (HB 2221)
  - Would enable parents to access child care provider compliance and licensing information on line
  - Gutted for the Clean Indoor Air bill in 2009

And Three Child Care Bills

- Oversight of registered family day care homes (HB 2223)
  - Would require registered day care homes to be fully licensed

Health in Every Policy

- KDHE and its health-care partners cannot create a healthy KS with programs alone
  - Schools, businesses, local government, faith-based organizations all have a bigger impact on health than we do
  - Working together we can build a healthy KS

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Impact of Budget Reductions in Medicaid and Alternative Sources of Savings

Testimony before the Senate Public Health and Welfare Committee
January 28, 2010

Dr. Andrew Allison, KHPA Acting Executive Director

1

Overview

- KHPA Budget Summary
- FY 2010 Governor's Allotments
- Expected impact of 10% reduction in provider payments
- Alternative sources of savings

2

Brief Overview of KHPA's Budget

- **KHPA's FY 2009 budget was about $2.6 billion**
  - $1.36 billion was non-SGF funding for KHPA medical programs
  - $800 million was federal funds passed through to other Medicaid service agencies (SRS, KDOA, JJA, KDHE)
  - $450 million was SGF funding for services and operations
- **KHPA programs and operations are funded separately**
  - FY 2009 operational funding was $23 million SGF (now $18 million)
  - Caseload costs are about 20 times larger than operational costs
  - Caseload savings cannot be credited to cost-saving operations
  - The federal government matches Medicaid operations at 50-90%
  - Operational costs for the state employee plan are funded off-budget through standard charges to agencies for each participating employee
- **Until November 2010, budget reductions were concentrated on operations**
  - Medicaid caseload protected due to Federal stimulus dollars
  - KHPA operational funding reduced 15.5% versus FY 2009

3

FY 2010 Governor's State General Fund Allotments

July 2009

• FY 2009 Caseload Savings	($5,300,000)
• Expansions to Pregnant Women	($524,000)
• Increased FMAP Rate	($6,300,000)

- <u>No impact on current services</u>

4

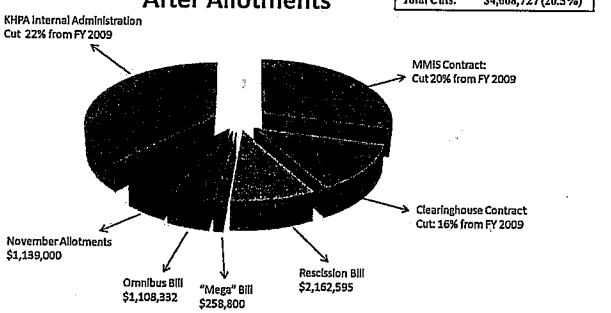
FY 2010 Governor's State General Fund Allotments *November 2009*

- **Caseload reductions**
  - Across-the-board 10% reduction in Medicaid provider rates
  - Limitation on MediKan benefits to 12 months
- **Administrative reduction of $1.13 million SGF**
  - Total impact is $2.5 million all-funds
  - Cumulative 20.5% reduction since approved FY 2009
  - Allotment represents 5% reduction on FY 2009 base
- **SCHIP reduction of $1 million SGF**
  - Growing backlog may reduce pressure on funding
  - Waiting to see the impact of the January 1st expansion in coverage to children up to 250% of the 2008 poverty level

5

FY 2010 Operating Budget After Allotments

FY 2009:	$22,814,018
Rev. FY 2010:	$18,145,291
Total Cuts:	$4,668,727 (20.5%)



Summary of November 2009 Allotment for KHPA Operations

- Freeze KHPA staff overtime and reduce KHPA staff through attrition (109,000) SGF
- Eliminate extra contract funding dedicated to the Clearinghouse eligibility backlog (140,000)SGF
- Cut State staff overtime dedicated to the Clearinghouse eligibility backlog (60,000) SGF
- Reduce scope of services in the Clearinghouse contract (197,000) SGF
- Amend verification policies and reduce call center capacity at the eligibility Clearinghouse (233,000) SGF
- Lapse funds from FY 2009 (150,000) SGF
- ~~Eliminate the call center for Medicaid providers and significantly reduce call center capacity for Medicaid beneficiaries (250,000) SGF~~

7

Focus: Eliminate Added Capacity at the Eligibility Clearinghouse

- Extra contract funding and state staff overtime dedicated to the eligibility Clearinghouse backlog
- Loss of funding will lead directly to growth in the backlog of applications, estimated backlog in June 2011 of 33,000
- Growing backlog will result in delayed or foregone medical care for beneficiaries and a loss of revenue for providers
- Creates the potential violation of federal 45 day processing time requirements
  - Threatens compliance linked to ARRA funding
  - Potential loss of up to $11 million in CHIPRA bonus payments
  - Potential threat to $40 million HRSA grant for improved eligibility operations

8

Focus: Examples of Simplifications to Medicaid/SCHIP Applications

- Self declaration of child support
- Eliminate trust test for "Caretaker Medical" (low-income parents)
- Self declaration of pregnancy
- Eliminate mid-year reporting for Transitional Medical recipients
- Continuous 12-month eligibility for caretaker medical (parents)
- Change income calculation for new applicants with new jobs
- Focus state workers on oversight and processing, not duplication
- Rely on Department of Labor wage information
- Pre-populate review form with lessened verification requirements
- New HW application designed to get questions answered accurately and to obtain necessary information

9

Focus: Eliminate Provider Call Center and Reduce Customer Service

- ~~Fiscal agent (HP) receives 250,000 calls per year from providers and beneficiaries,~~
- ~~Call volume may divert to KHPA staff, where there is no capacity~~
- ~~Payment accuracy likely to decline, resulting in higher caseload costs~~
- ~~No in-person training for new providers or changes in billing~~
- ~~Strain in relationships with Medicaid Providers~~
- ~~Increase in payment appeals~~

→ **UPDATE: KHPA and HP have announced a negotiated deal to protect these services at current levels**

- → HP will receive an accelerated contract extension plus two added option years
- → KHPA receives a lower per-claim processing charge in return: savings are applied to maintain services

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Implementing the 10% Rate Reduction

- The "Budget Shortfall" payment reduction applies to the Medicaid paid amount (net reimbursement amount)
- Reductions are effective with dates of service on and after January 1, 2010
- The reduction applies to all providers as indicated in the public notice, published in the Kansas Register, December 17, 2009
  - HealthWave MCOs will pass the reductions through beginning in March or April, following mandatory advance CMS approval of the reduced capitation payments
  - The reduction will apply to paid claims, Medicaid disproportionate share payments, graduate medical education payments, critical access hospital settlements, Rural Health Clinic (RHC) cost settlements, Federally Qualified Health Center (FQHC) cost settlements, payments for Home and Community Based Services (HCBS) waivers, targeted case management, psychiatric residential treatment facility (PRTF), nursing facility for mental health (NF/MH), community mental health center (CMHC), substance abuse, head injury rehabilitation, and other payments.
  - The reduction does not apply to state institutions (University of Kansas hospital, state psychiatric institutions), nor to payments set by Federal regulation (i.e., through Medicare)

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Financial Impact of the 10% Reduction

- At least $18 million in savings to the state expected in FY 2010
  - About $8 million SGF for payment reductions to fee for service medical care providers
  - More than $10 million in expected savings through Medicaid services overseen by SRS and KDOA
  - Additional reductions through HealthWave managed care (pending CMS approval)
- The current federal matching rate is approximately 70%
- Providers experience the all funds reduction
  - Impact on providers is more than three times the savings to the state (1/.3 = 3.3)
  - Providers will experience a $58 million reduction in payments in FY 2010
- Foregone Federal matching payments of approximately $40 million in FY 2010
- The impact in FY 2011 will be more than twice as great if the reductions continue
  - Full year impact on providers would be at least $200 million
    - State savings in FY 2011 would be at least $70 million
    - Foregone Federal matching payments would be at least $130 million
  - ARRA stimulus payments expire in December 2010, after which the state match reverts to about 60%

12

Provider Response to Medicaid Budget Reductions

- Rate reduction has prompted a strong reaction from a wide spectrum of providers
  - Impact is likely to vary by type of provider
  - Impact of rate cuts different if providers view it as permanent
  - Many have expressed concerns about the impact reductions will have on access to providers for Medicaid and SCHIP recipients
- Providers expressed some of their deepest concerns over the potential reductions in customer service and support
  - A majority of KHPA administrative costs are outsourced through competitively bid contracts (fiscal agent; eligibility clearinghouse)
  - Alternative sources of administrative savings are limited and reduce capacity to manage caseload costs and oversee private contractors

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Alternative Savings in Medicaid

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Reducing Medicaid Spending: Overview

- Medicaid spending is determined by four key factors
  - People covered, e.g., elderly, disabled, children and families, MediKan, foster care, etc.
  - Services provided, e.g., hospital services, pharmacy, mental health, nursing homes, community-based care, home health, hospice, etc.
  - Rates paid to each type of provider
  - Utilization of each service by each beneficiary
- Opportunities for reductions in spending differ
  - Up to half or more (55%) of Medicaid spending in Kansas is "optional" by Federal law
  - People covered
    - ARRA requires states to maintain eligibility through January 1, 2011
    - House and Senate health reform bills would extend that requirement indefinitely
  - Services provided
    - Some of the most expensive services are mandated by Federal statute
    - Optional services are not protected in ARRA
  - Rates
    - Rates are set, by and large, by fee schedule
    - Current ten percent reduction is at the upper end of imposed cuts nationally
  - Utilization of services
    - Health care management is intended to reduce unnecessary care and improve quality prevention

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Reducing Medicaid Spending: People Covered

- Distribution of spending across all populations varies widely
  - Low income families and children comprise about half of Medicaid enrollment (52% in FY 2009) and account for one-fifth of spending (21%)
  - Aged beneficiaries comprise about one tenth of Medicaid enrollment and account for nearly one-quarter of spending (23%)
  - Disabled beneficiaries comprise about one fifth of enrollment (18%) and account for nearly half of spending (47%)
- Spending for optional covered populations is concentrated among the elderly and disabled
  - SCHIP coverage of Children above 100% to 150% of poverty, depending on age, totals approximately $64 million AF (FY 2009)
  - Medicaid coverage of Newborns aged 0-1 between 133% and 150% of poverty could not be reduced without first eliminating SCHIP (no current estimate)
  - Spending on optional Aged and Disabled populations totals approximately $163 million (FY 2009)

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Reducing Medicaid Spending: Services Provided

- Optional services comprise about 31% of total Medicaid spending
- No medical services are optional for children
- Largest optional services for adults
  - Home and community based service waivers ($577 million AF; $175 million SGF)
  - Prescription drugs ($116 million AF; $38 million SGF)
  - Hospice services ($27 million AF; $8 million SGF)
  - Targeted case management for the MR/DD population and ICFs/MR (each about $13 million AF; $4 million SGF)
- Largest optional services are preferred substitutes for mandatory services
  - Eliminating optional services would cause harm to beneficiaries
  - A significant percentage of spending on optional services would shift to other, more intensive services
    - pharmacy, hospice, mental health → inpatient hospital
    - HCBS → nursing facilities

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Reducing Medicaid Spending: Health Care Management and Quality Improvement

- Recent KHPA initiatives
  - Health Promotion for Kansans with Disabilities Transformation Grant
  - Enhanced Care Management Pilot Project
  - Community Health Care Record Pilot Project
  - Commonwealth State Quality Institute Phase I & II
  - Vermont Medical Home Technical Assistance Initiative
  - National Academy of State Health Policy State Consortium to Advance the Medical Home for Medicaid and CHIP Programs
- KHPA Board has requested a review of the net impact of HealthWave managed care
- LPA has engaged a study of the impact of extending managed care

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Reducing Medicaid Spending: Health Care Management and Quality Improvement

- Recent Measures Taken by Administrative Action
  - Transformation Recommendations Implemented
    - Reasonable pricing requirements for durable medical equipment
    - Outsourced management of non-emergency transportation
    - Developed diabetes management initiative for home health
    - (Pricing reforms in home health are in process)
    - Published performance and quality data for HealthWave
    - Established the Mental Health Advisory Committee
    - Automated Prior Authorization for Select Pharmaceuticals
    - Increased Presumptive Eligibility Sites

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Reducing Medicaid Spending: Health Care Management and Quality Improvement

- Reduction Options Included in FY 2011 Budget Submission
  - Streamline Prior Authorization in Medicaid
    - Savings of $243,000 SGF/ $952,000 AF
    - *Requires new appropriation for outsourced technology and support*
  - Mental Health Pharmacy Management
    - Savings of $800,000SGF/ $2.0M AF
    - *Entails a change in state law to allow use of standard pharmacy management tools*
  - Align Professional Rates in Medicaid
    - Savings of $ 1 M SGF/ $ 2.8 M AF
    - *This option was implemented in conjunction with the 10% provider payment reduction*

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Cost-Saving Measures Taken by Other States

- Options Kansas Medicaid has already taken
  - Reductions in provider rates
  - Placing limits on community based long term care services, home health services, and private duty nursing
  - Intensifying prescription drug utilization and cost control initiatives
  - Chronic care management
  - Behavioral health utilization review
  - Post payment and hospital outlier review
  - Reduction in MCO administrative reimbursement
- Other options
  - Long term care managed care
  - 30 day no re-admit hospital policy for the same diagnosis
  - Coordination of behavioral health with physical health care
  - Incorporation of durable medical equipment costs into Home Health Nursing Home per diems
  - Eliminating optional services, e.g., hospice
  - Imposing new or higher copayment requirements, e.g., for pharmaceuticals

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Optional Spending in Kansas Medicaid

	Actual spending		*Projections based on November 2008 Caseload*			
	FY 2008		***FY 2009***		***FY 2010***	
	SGF	**All Funds**	***SGF***	***All Funds***	***SGF***	***All Funds***
Optional Services	315,644,342	757,173,932	*332,319,658*	*802,604,368*	*348,957,886*	*850,760,630*
Optional Populations	362,042,178	925,137,267	*383,764,709*	*980,645,503*	*402,757,392*	*1,039,484,233*
Less Crossover*	(136,255,927)	(324,321,565)	*(144,431,282)*	*(343,780,859)*	*(151,683,257)*	*(364,407,710)*
Total Optional Medicaid Spending	541,430,593	1,357,989,634	*571,653,084*	*1,439,469,012*	*600,032,021*	*1,525,837,153*
Total Medicaid Spending (excludes administration)	981,579,148	2,425,432,536	*1,040,473,897*	*2,570,958,488*	*1,102,902,331*	*2,725,215,997*
Optional Medicaid Spending as a Percentage of Total Medicaid Spending	55%	56%	*55%*	*56%*	*54%*	*56%*

* Reflects optional services provided to optional populations. See note 3 below.

Key assumptions and caveats:

1. Under federal law, all children's services are mandatory due to participation in KAN Be Healthy, Kansas' Early Periodic Screening, Diagnosis and Treatment (EPSDT) program.

2. Spending on many optional services is a substitute for state-only programs and/or spending on mandatory Medicaid services. Much of the spending associated with optional services cannot be avoided.

3. Estimates include all spending on optional benefits or optional populations. Dollars attributable to optional services provided to optional populations are subtracted to eliminate double counting (i.e., "crossover" dollars).

4. Estimates do not include spending attributable to reimbursement rates that exceed regulatory minimums.

5. For more specific information on mandatory Medicaid spending, see: Mandatory and Optional populations, 42 CFR 435; and services, 42 CFR 440.

6. Estimates do not include pregnant women and infants betwee 134% and 150% of the federal poverty level. This covered population exceeds Federal minimums, but could only be reduced if Kansas' SCHIP program were first elmiinated. In addition, mandatory and optional spending for this population is not tracked in the Medicaid payment system and would require significant additional estimation.

7. Optional populations and services included in this analysis are listed below:

Optional populations
- Medikan
- Working Healthy
- Breast and Cervical Cancer
- Medically Needy Aged
- Medically Needy Disabled
- Medically Needy Families
- Aids Drug Assistance Program
- Tuberculosis
- Foster Care Aging Out
- SCHIP

Optional services
- Ambulatory Surg Ctr
- Maternity Center
- Pharmacy
- Vision
- Dental
- Local Health Dept
- Attendant Care for Indepent. Living
- Hospice
- CMHC
- Psychologist
- Transportation
- Chiropractor
- Podiatrist
- Hearing Services
- Equip,Supplies,Orthotics/Pros.
- FQHC's, RHC's
- Alcohol & Drug Treatmt
- Dietitian
- Head Start
- Physicial Therapist
- Behavior Managment
- Head Injured Rehab. Facility
- Local Education Agencies
- TargetCase Mgmt -CMRCs
- CDDO's
- TargetCase Mgmt -Frail Elderly
- Nursing Facility Pre Screening

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January 28, 2010
Follow Up Questions for Senate Public Health and Welfare

I. How are the upper dosage limits set?

The Kansas Medicaid Program has limitations on some narcotic prescriptions, and will be adding additional restrictions on short-acting opioids based on the final recommendations of the DUR Board from their January 2010 meeting, finalizing a process that began in July 2009 with the DUR Board's initial discussion of additional narcotic limitations. Limitations are based on a combination of FDA recommendations, American Pain Society Guidelines, and the clinical experience and expertise of the DUR Board members. Long-acting opioids were reviewed for inclusion on the preferred drug list in June 2009.

Current Limitations

Drug Name	System Edit Limitations[1] (per 30 days)
Acetaminophen (APAP) Products	120,000mg
Aspirin (ASA) Products	120,000mg
Hydrocodone/APAP	120,000mg (APAP)
Hydromorphone	1,440mg
Meperidine	36,000mg
Oxycodone	14,400mg (Oxycontin products only)
Oxycodone/APAP	120,000mg (APAP)
Propoxyphene products (with or without ASA)	11,700mg
Tramadol	12,000mg
Fentanyl, transmucosal	4 units/day (regardless of strength)

[1] A 'Super Prior Authorization' is available as an exception.

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

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

Proposed Limitations

Drug Name	Daily dose limitation (per claim)	Monthly cumulative dose limitation (per 30 days on all claims)
Morphine Sulfate	200mg	6000mg
Codeine	1333mg	39990mg
Hydrocodone	200mg	6000mg
Hydromorphone	50mg	1500mg*
Oxycodone	133mg	3990mg
Oxymorphone	67mg	2010mg

*1400mg/30 days limitation on hydromophone currently in place

II. Outline the SURS review process?

The purpose of the Lock-In Program is to reduce expenditures through a reduction of self referrals to multiple care providers. It also provides for case management and continuity of care.

Referrals of beneficiaries to the lock-in program may come from a variety of sources including the SURS unit of the fiscal agent, the DUR board, KHPA, the Quality Assurance unit of the fiscal agent, or providers. Once identified, cases are assigned to a Nurse Analyst with the SURS unit for review. The analyst reviews the beneficiary's claim history to identify patterns such as obtaining same or similar services for the same or similar diagnosis from more than one provider, accessing emergency department care for non-life threatening conditions, using more than one prescribing physician to obtain drugs from the same therapeutic class of medication, or using more than one pharmacy to obtain or attempt to obtain drugs from the same therapeutic class of medication.

If the beneficiary meets one or more of the Lock-In criteria, the beneficiary is "locked in" to one provider, one pharmacy and, if necessary, one hospital for two years. Some beneficiaries, such as those who have forged or altered a prescription, are placed directly on lock-in. Beneficiaries who do not meet the criteria for placement on Lock-In may be educated and then re-reviewed at a later date.

Once placed on lock-in, a review is conducted toward the end of the initial two year period, and the beneficiary may either be removed from the Lock-In program or placed on extended lock-in. Extended lock-in lasts as long as the beneficiary receives a medical card. Beneficiaries removed from the Lock-in program are reviewed in six to twelve months to determine if the abusive behavior returned.

In addition to referrals, beneficiaries are identified for potential lock-in from reports that are run at least quarterly by the SURS unit. The following are examples of the reports that are run.

Beneficiary Peer Group Comparison Report
This report displays and compares all beneficiaries within a peer group to determine which beneficiaries fall outside of service dollar "norms". All information including age, sex, and morbidity is adjusted so that differences in patient mix do not affect the results. This report can look at Professional Service Totals, Professional Referral Totals, Inpatient Referral Totals, Outpatient Referral Totals, Nursing Facility Totals, and Pharmacy Totals. Beneficiaries who are two standard deviations above or below the "norm" for the peer group are highlighted. This report provides a rapid method to find which beneficiaries need to be analyzed more closely utilizing other reports within the DSS Profiler.

Multiple Pharmacies Report
This query identifies beneficiaries with dispensing of specific drugs from three or more pharmacies during a single calendar month. Pharmacy claims billed for drugs in specified therapeutic classes would be reported when the beneficiary received dispensing from three or more pharmacies during a single calendar month.

Multiple Prescribers Report
This query is used to identify beneficiaries with prescriptions for controlled substances/narcotics written by multiple prescribing physicians. This targeted query identifies beneficiaries with prescriptions for controlled substances/narcotics written by three or more different prescribing physicians.

III. How could we prevent a Medicaid beneficiary from using a non-Medicaid physician, by paying in cash, to obtain a prescription to be paid for by Medicaid at the pharmacy?

It would be possible to require the NPI number submitted on a pharmacy claim to match with a prescriber enrolled in Kansas Medicaid. Preliminary research into prescribers of controlled substances indicates that of the 500 top prescribers, only approximately 5% are not enrolled as Medicaid prescribers. We plan to look further into the role that non-participating prescribers might have in supporting the misuse of controlled substances in the Medicaid program, and will examine the system changes required to further scrutinize or limit reimbursement for prescriptions written by non-participating providers, as well as any potential impact on beneficiary access to care.

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Monitoring the use of Controlled Substances in Medicaid: KHPA Current Practice

Currently, several schedule II-IV narcotics have upper dosage limits which require beneficiaries to obtain a prior authorization in order to exceed that dosage. Short-acting opioids were presented at the January 2010 Drug Utilization Review (DUR) Board meeting for continued evaluation of adding several additional dosage limits, finalizing a process that began in July 2009 with the DUR Board's initial discussion of additional narcotic limitations. Board discussion resulted in establishment of dosage limitations for six short-acting opioids.

In preparation for the DUR board meeting, six months of narcotic utilization was examined to identify claims for narcotic doses higher than limits suggested in guidelines issued by the American Pain Society. Expenditures on claims exceeding the American Pain Society's high dose limit for these narcotics were less than $50,000. Though in comparison to the approximately $90 million of pharmacy expenditures in the same timeframe this is a relatively small sum, closer monitoring of narcotic use will decrease fraud and abuse in the Medicaid population, as well as alerting providers to potential narcotic abusers via alerts and prior authorization requirements implemented through pharmacy point of sale transactions.

The DUR board reviews narcotic utilization and prescribing on average one or two times each year and the Retrospective DUR subcontractor reviewed controlled substance utilization data in June 2009.

The dosage limitations approved by the DUR Board in January will likely result in additional referrals to lock-in. While the new limitations will not result in additional claims appearing on the standard SURS report, we anticipate that referrals received from pharmacy providers will increase as they are alerted to beneficiaries exceeding acceptable dosage limitations at the point of sale. Additionally, the prior authorization unit may refer more beneficiaries as they receive requests to exceed the high dose limits.

For specific beneficiaries identified as participating in suspect use of Medicaid coverage, lock-in programs (denying use of Medicaid funding to any provider other than the one specified for the beneficiary) can be implemented. Beneficiaries can be "locked-in" to a single physician, single pharmacy, single emergency room, or any combination of those three. Important to note is that beneficiaries could potentially skirt these restrictions by paying out of pocket for services.

The Surveillance and Utilization Review/Fraud and Abuse (SURS/FADS) unit generates reports quarterly which monitor beneficiaries' utilization of controlled substances against established "norms", adjusted by age, gender and morbidity. Those beneficiaries that fall outside of the norm are evaluated for our lock-in program. Beneficiaries suspected of abuse of their medical coverage, including overuse of schedule II-IV narcotics, can also be identified through referrals from prescribers, pharmacies, anonymous reports, or other fiscal agent units, such as the pharmacy unit.

Once identified for suspect behavior, the beneficiary is reviewed by one of the 13 utilization review nurses in the SURS/FADS unit. The time required to complete each beneficiary review is estimated to be approximately 40 hours, and the total administrative costs to establish each lock-in participant is about $2,000. There are 362 beneficiaries in the lock-in program at this time with an active eligibility status and an additional 285 beneficiaries who have lost their eligibility but still meet lock-in criteria that we continue to monitor. Once eligibility is regained they will automatically be placed back in the Lock-In Program.

In addition to beneficiary reviews, the utilization review nurses also perform reviews and generate quarterly reports of providers prescribing and dispensing practices (physicians, pharmacies) to ensure compliance with Medicaid regulation, and recoup payments from those providers if inappropriate payments are identified. Providers who are suspected of inappropriate prescribing or dispensing of controlled substances are referred to the Peer Education Resource Committee (an advisory board comprised of physicians, a pharmacist, and a mid-level provider that reviews provider practices to ensure quality and adherence to current standards of care) and possibly their licensing and oversight board.

Activities in other States

Medicaid programs in most other states have mechanisms in place to prevent fraud, abuse and diversion of controlled substances that are similar to those in Kansas. These include point of sale edits, dosage limitations, prior-authorization of controlled substances above the recommend dosing level and lock-in programs.

As of September 2009, 33 states have operational Prescription Drug Monitoring Programs (PDMP) that have the capacity to receive and distribute controlled substance prescription information to authorized users. States with operational programs include: Alabama, Arizona, California, Colorado, Connecticut, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Nevada, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Vermont, West Virginia, and Wyoming.

Seven states (Alaska, Florida, Kansas, Minnesota, Oregon, New Jersey and Wisconsin) and one U.S. territory (Guam) have enacted legislation to establish a PDMP, but are not fully operational.

The Kansas Board of Pharmacy was awarded two grants in 2009 to implement the Kansas Prescription Drug Monitoring Program. These were the Harold Rogers grant from the federal Bureau of Justice Assistance in the amount of $400,000 over two years, and the Substance Abuse and Mental Health Services Administration (SAMHSA) National All Schedules Prescription Electronic Reporting Act (NASPER) formula grant totaling $66,407 over one year. No money has been appropriated by the legislature to support this program. The Medicaid Pharmacy Director sits on the steering committee for the Prescription Drug Monitoring Program and is working with the committee to prevent fraud, abuse, and diversion of controlled substances.

KHPA Future Plans

Data-driven, cost-effective management of the Medicaid Pharmacy Program has been an area of focus in recent years and continues to be for FY11. Enhanced management of pharmacy expenditures through

mechanisms such as pricing initiatives related to generically available drugs, internal development of an automated prior authorization system, and expansion of the preferred drug list occurred in State Fiscal Years 2009 and 2010.

Fiscal Years 2011 initiatives include requests for legislative funding of an enhanced automated prior authorization system, which will greatly expand the prior authorizations currently employed by Kansas Medicaid, and repealing of the statute that prevents industry-standard management of mental health drugs such as utilization edits and prior authorizations to ensure safe and appropriate use of mental health medications, placement of mental health drugs on the preferred drug list, and allowing market competition to provide cost savings. The enhanced prior authorization system would allow Medicaid to better monitor the use of controlled substances as well.

Finally, the Medicaid Pharmacy Program is developing new point of sale edits to reinforce current dosage limitations on the use of large quantities of Oxycontin and other controlled substances. Medicaid will continue to generate the quarterly beneficiary utilization, and provider prescribing and dispensing reports. These reports will be distributed to the DUR board and PERC committee as needed. Aggregate data will be shared with providers through our newsletter.