Approved: 05/05/10
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 March 3, 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
Amanda Nguyen, Kansas Legislative Research Department
Jan Lunn, Committee Assistant
Melissa Calderwood, Kansas Legislative Research Department

Conferees appearing before the Committee:
Dr. Andrew Allison, Kansas Health Policy Authority

Others attending:
See attached list.

Discussion (continued from 03/01/10) Kansas Health Policy Authority - Report on short- and intermediate-term alternatives for Medicaid Savings

Dr. Andrew Allison, Executive Director, Kansas Health Policy Authority, was present to continue discussion on the presentation from March 1, 2010.

Dr. Allison addressed several issues arising from Monday's meeting centering on managing care for the disabled and elderly (PACE and SNP programs), Medicaid Reinvestment Proposal, and ongoing activity concerning controlled substances. Dr. Allison distributed two handouts: "Reduced Resource Package: Streamlining Prior Authorization in Medicaid" (Attachment 1) and "Budget Option: Medicaid Reinvestment Fund" (Attachment 2).

Dr. Allison focused on three items requiring follow-up for management of controlled substances and diversion of prescriptions in the Medicaid program (Attachment 3). He described the imposition of new limits on individual narcotic prescriptions based on recommendations of the Drug Utilization Review Board (DUR). Dr. Allison indicated additional limitations for long-acting narcotics will be discussed at the April DUR Board meeting. A comparison of FDA recommendations to American Pain Society recommendations and current/proposed DUR Board limitations for oral Opiod analgesics was reviewed. Dr. Allison also reported that the possibility of restricting dispensing narcotics to those providers enrolled in the Medicaid is under review. Dr. Allison shared that purchase and implementation of an automated prior authorization system is necessary to impose limitations on multiple narcotic prescriptions; however, funding for the system is unavailable at the current time.

The care management of the aged and disabled population was discussed. This population generates the highest healthcare costs, and several programs are available to generate savings: Program for All-Inclusive Care for the Elderly (PACE) and Special Needs Plan (SNP). Dr. Allison described these plans indicating State savings are difficult to project; however, these types of programs will, in the long-term, reduce healthcare costs. SNPs through Medicare Advantage will only generate savings to Medicare; however, Dr. Allison stated a similar model could be adapted into the Medicaid population with savings opportunities ultimately distributed to the State. In the State of Kansas, the number one source of Medicaid admission is psychiatric related. Dr. Allison indicated better healthcare management of that population is required; therefore, Kansas must work with stakeholders to invest in themselves by selecting appropriate care models, reviewing funding sources/plans, and required capital investment, etc.

Dr. Allison described a budget option, Medicaid Reinvestment Fund, involving policy, procedure, and technology changes that would save Medicaid assistance money but would require up-front investment to achieve the savings. The focus is on transitions for the aged and disabled that reduce

hospital readmissions and integrate coordination from the inpatient team to the outpatient environment and healthcare providers. This creates an integrated model to reduce healthcare costs and allow for reinvestment of realized savings. The proposal allows identified caseload savings to be partially reinvested in order to make these up-front investments in a timely manner. Savings could be used for the purchase of a prior authorization system. Dr. Allison also discussed the proposal to send a privilege fee for insurance to Managed Care Organizations (MCO). Dr. Allison referred to page 28 from the resource distributed on March 1, 2010 ("Kansas Health Policy Authority - Medicaid Savings Options"). This proposal, in which payments are sent back to the MCOs, will also include a federal matching payment of approximately 70%, which means the State will net about 70% of the tax which could be used for other purposes. Dr. Allison referred to "Option 3" on page 29 of the handout and described possibilities for using additional funds.

Dr. Allison recommended the following:

- Evaluate the use of Medicaid Reinvestment Fund using part of the consensus caseload process to reap savings for new or previously approved administrative investments (i.e., prior authorization software). This proposal requires controls to ensure agreement on how savings are identified and how much money could be reinvested. A logical control would be to cap the amount allowed into the fund for use. The Medicaid Reinvestment Fund would be subject to annual appropriation and submitted in the budget to the Governor.
- Savings from implementation of prior authorization software would begin in year two (FY 2012 and beyond) and could be used to invest in better care management for Medicaid beneficiaries with chronic discases.
- In FY 2010, the MCO privilege fee revenue begins to accumulate; proceeds could be used to feed the Medicaid Reinvestment Fund.

Chairperson Barnett recognized Bob Finuf, chief executive officer, Children's Mercy Family Health Partners, to address the mechanics of the MCO privilege fee proposal (Attachments 4 and 5). Mr. Finuf spoke on behalf of the Medicaid HMOs (CMFHP, UniCare, and Value Options). He indicated that in FY 2010, approximately $3.1 million would be available resulting from the MCO tax. Mr. Finuf indicated his group wants to enhance, restore, or partially limit reduction in provider payments and/or to generate or leverage federal funds.

Additional discussion was heard concerning the expansion of the tax to non-Medicaid HMOs in order to generate additional savings or draw down additional federal dollars. Questions to Dr. Allison included how to best manage care for the disabled and elderly. Dr. Allison responded the management of this population is a growing concern for KHPA. Because providers as well as beneficiaries must be part of plan development, KHPA is hesitant to recommend a solution. Dr. Allison suggested national experts, such as the Center for Healthcare Strategies, be brought in to facilitate conversation and collaboration in order to arrive at the best options for Kansas.

Senator Schmidt thanked the MCOs for their proposal concerning the privilege tax; she indicated provider input is required for resolution, and she expressed doubtful concern that solutions can be formed if a 10% reduction in provider reimbursement continues. Senator Schmidt commented that many providers may opt out of the Medicaid program due to their inability to provide services for which they receive little reimbursement. While Senator Schmidt indicated her support for a chronic disease management model such as the Asheville Project, she encouraged management of the 10% reimbursement reduction crisis by directing proceeds to restore provider reimbursement until a sound footing is secured.

Senator Colyer inquired who makes the decision concerning the disposition of potential savings. Dr. Allison clarified that the legislature, budget office, governor's office, etc., review proposals from the consensus caseload process; the legislature is accountable to appropriate monies.

Chairperson Barnett suggested a letter be crafted to the Senate leadership containing direction related to how monies generated by the privilege fee should be disbursed. Dr. Allison clarified that KHPA needs direction from the legislature concerning options discussed that would reinvest dollars in the Medicaid program in order to maximize federal matching funds. If monies are to be used to partially restore the provider rate cuts in Medicaid, KHPA must amend payments to contracting

Minutes of the Senate Public Health and Welfare Committee at 1:30 p.m. on March 3, 2010, in Room 546-S of the Capitol

MCOs within the next several weeks so that the MCOs can pass federal matching funds generated from the privilege fee through to the doctors, hospitals, and other providers participating in the MCO networks.

Senator Schmidt reiterated her thought that monies should be directed to provider reimbursement. Senator Barnett requested the opportunity to draft a letter to the Senate leadership for review by committee members on Monday, March 8, 2010.

The meeting was adjourned at 2:26 p.m.

PUBLIC HEALTH AND WELFARE
GUEST LIST
March 3, 2010

NAME	AFFILIATION
Chad Austin	KHA
Dustin Moya	KHPA
Jackson Gridley	Hein Law
Rob Moore	Kennedy & Assoc.
John C. Tolbert	CMFHP
Chad Moore	CMFHP
Shanna Wikle	KAC
Lan Hoang	SRS
Chris Gigstad	Federico Consulting
Levi Henry	Smoketree Group LLC
Ted Hamby	Capitol Strategies.
Brad Ingrot	FHP
Amy Campbell	KMHC
Jamal Porter	United Health Group
Karen Ann Brown	CMH
Jennifer Crow	Children's Alliance

Reduced Resource Package: Streamlining Prior Authorization in Medicaid

Description: KHPA would implement an enhanced prior authorization (PA) system to increase the automation of and expansion of the decision rules used to evaluate requests for medical services.

Background: The proposal would enhance and automate the existing PA system. Kansas Medicaid currently operates a manual PA system for medical services and is building an automated process for pharmacy. Manual PA requests are submitted by mail or fax and simple requests are reviewed by nurses. Pharmacists review all prescription requests that fall outside of established criteria. With nearly 6,000 PA requests annually (~16/day), the review process requires a large investment of staff time.

Automated PA programs intercept inappropriate claims during the point of sale transaction, while allowing claims that meet evidence-based guidelines to be paid and filled. The criteria for approving the PA requests can be programmed into an electronic system, increasing efficiency at the pharmacy and in the Medicaid program. Approximately 80% of PA requests are approved after evaluating the information submitted by providers with established clinical criteria. The pharmacists and other clinical personnel that now review that information could spend their time more productively managing other aspects of the Medicaid drug program. Additionally, electronic clinical and financial editing would allow Medicaid to expand the number of claims reviewed through the system without an undue administrative burden on providers or the state. This added capacity would allow the state to expand the number of drug classes on the preferred drug list from the current 34 classes. Since implementing an automated PA system, Missouri has expanded from 12 to 100 drug classes.

To implement enhanced PA, KHPA would issue a request for proposals for a data system and customer service support. The contractor would introduce a system to interact with the Medicaid Management Information System. The system would query patients' medical and pharmacy claims history in real time to determine the appropriateness of therapies based on established best practices criteria. Physicians and pharmacists will receive real time notification, generally within seconds, of PA denials or requirements for additional information allowing them to select more appropriate therapy at the point of care.

Population Impacted: This option would be implemented statewide and would affect the entire Medicaid and HealthWave population.

Budget Impact: The proposal would save funds in FY 2011 by putting PA criteria in place sooner. To estimate the impact of shortening the process for approving PA criteria, KHPA identified several drugs and drug classes that have been identified for PA and completed the rules process. Based on the last three PA regulations that have been implemented, putting them

in place four months earlier would have saved an additional $82,000. These three drugs saved a total of $328,000 during FY 2008, but took six months to be implemented.

We also compared savings if the approval process and implementation process in the payment system was faster using an automated PA system. For the proton pump inhibitor (PPI) drug class, it took 33 months from approval of the regulation to implementation in the payment system. Once the PA was implemented in February 2008, prior authorization of PPIs saved $70,000 each month. If the PA could have been implemented in 12 months, the state could have saved $1,470,000 more with the PA applied for 21 additional months. This is as an example of implementing PA criteria faster across additional drug classes.

The proposal would use savings generated from automating prior authorizations to pay for the additional contract costs needed to acquire an enhanced PA system. Based on preliminary conversations with vendors, the cost of implementing a system is between $500,000 and $750,000, with similar annual operating costs.

PCA Code	All Funds	SGF	Fee Fund
35000 (Medicaid assistance savings	($1,552,000)	($543,000)	
34200 (contract cost)	$600,000	$300,000	
Total Impact	($952,000)	($243,000)	

Considerations: Accelerating the procurement process to run during FY 2010 in tandem with the legislative review of the budget allows KHPA to achieve savings from enhanced PA in FY 2011 that will more than offset the cost of implementation. In future years, there would be additional cost savings from the expanded PDL and increased supplemental drug rebates associated with the expanded PDL.

The development of an enhanced PA system may take six to nine months to implement. The request for proposal process alone would take several months and any contract would require approval by the state information technology office and the Centers for Medicare and Medicaid Services (CMS). The system enhancement would require careful integration with the existing MMIS and how claims are processed.

Staff Recommendation: Include in KHPA budget recommendations to the Governor.

Board Action:

Approved by Board on 9-15-09 to include in agency's budget submission.

Budget Option: *Medicaid Reinvestment Fund*

Description: Policy, procedure, and technology changes that would save money in the Medicaid assistance budget often require some up front spending to achieve the savings. The proposal would allow identified caseload savings to be partially reinvested in order to make these up-front investments in a timely manner.

Background: KHPA separately budgets administrative matching funds and assistance matching funds. Administrative funds are used to pay the fiscal agent to process and support the claims payment process, to pay for an outsourced eligibility operation to answer calls and process applications, to employ staff to identify cost effective ways of purchasing care, oversee large outsourced operations, and develop policy to improve the Medicaid program, and to work with contractors to provide expertise and technical capacity not available within KHPA. These functions are vital to a well run health insurance program and are the basic tools available to the state to identify and implement cost savings.

Over the past several years through the Medicaid program review process, KHPA staff have identified several administrative changes that would reduce Medicaid expenditures and provide more efficiently delivery of care. These efforts often require an initial investment in administrative costs that leads to Medicaid program savings that can be captured in the Consensus caseload process. Budget reductions since FY 2009 limit KHPA's flexibility to fund innovations that could create such savings. The structure of the budget prevents KHPA from using savings in caseload assistance programs to pay for the administrative investments that generate those savings. Without a specific new appropriation, KHPA lacks the flexibility to take advantage of cost-saving investments in the administration of the Medicaid program.

The Medicaid Reinvestment Fund would allow for a portion of the savings realized from a specific policy change or initiative to be used to pay the administrative cost of implementation, and to finance a limited number of additional cost-saving investments. The Medicaid reinvestment fund would be a mechanism for agencies to identify a predictable source of funding for cost-saving initiatives, promoting innovative program management with a mechanism to monitor return on investment. One common example would be to invest in cost saving services or technology on a pure contingency basis – a practice numerous vendors have suggested – where the contractor is paid only when caseload savings can be documented. The fund would be overseen within the regular budget and appropriation cycle with the added control of the consensus caseload process.

How would the fund work? KHPA would develop a policy option specifying how Medicaid would be changed, how much is expected to be saved from the actions, and how much would be spent on the investment(s) each year. Each proposed investment would be reviewed as part of the Consensus caseload process to reach an agreement on the estimated savings amount and the amount available for new or previously approved administrative investments. At subsequent Consensus meetings, the amount of actual savings and administrative costs for each investment initiative would be tracked to ensure

that legislative limits on the total amount of investments was not exceeded, and to ensure that a positive amount of savings are flowing out of the Reinvestment Fund and back into the State General Fund. On an annual basis, KHPA would certify to the Director of the Budget the total amount that should be transferred into the Medicaid Reinvestment Fund to pay for the administrative costs of its reinvestment initiatives. This could be a reimbursement of an expense already made by KHPA or funds advanced for a savings initiative that requires an initial investment. Except in the first eighteen months of the program, the total amount transferred into the Medicaid Reinvestment Fund each year could never exceed the amount saved through its initiatives in that year. If a savings measure did not save assistance dollars within the expected time period, the reinvestment fund would be used to repay the cost of assistance or refund the State General Fund. The Fund and all associated investment initiatives would be discontinued if total net savings were not realized during the first eighteen months of operation, and at any time thereafter when the fund is insufficient to finance the investments that have been made. Savings exceeding the limited amount of investment would revert to the State General Fund through the caseload process.

Example: KHPA has proposed adopting a smart prior authorization (PA) system to use more automated functionality to accelerate and apply more complex criteria to prior authorizations for prescription drugs and health care services. This mechanism would save assistance expenditures by reducing unneeded or conflicting services based on rules KHPA would develop. The smart PA tool and rules require an initial investment in software and programming before the realizing the savings. The following table illustrates the hypothetical impact of an investment of $600,000 in the first year when $800,000 of first year savings is returned to the state.

Medicaid Improvement Investment Fund - Immediate return				
	Year 1	**Year 2**	**Year 3**	**Year 4**
Initial Investment	600,000			
on going cost		400,000	400,000	400,000
Total Costs	**600,000**	**400,000**	**400,000**	**400,000**
Savings measure agreed to in caseload	800,000	1,250,000	1,375,000	1,512,500
Net Savings	**800,000**	**1,250,000**	**1,375,000**	**1,512,500**
Costs (Savings)	**(200,000)**	**(850,000)**	**(975,000)**	**(1,112,500)**
All amounts from State General Fund				

In most cases, an investment will take two or more years to generate sufficient savings to pay its total cost. That is shown in the following table. By the end of the 4th year, the initial investment and ongoing costs are repaid with additional savings accrued to the State General Fund.

Medicaid Improvement Investment Fund - 2 year return				
	Year 1	Year 2	Year 3	Year 4
Initial Investment	600,000			
on going cost		400,000	400,000	400,000
Total Costs	**600,000**	**400,000**	**400,000**	**400,000**
Savings measure agreed to in caseload	125,000	375,000	625,000	1,512,500
Net Savings	**125,000**	**375,000**	**625,000**	**875,000**
Costs (Savings)	**475,000**	**25,000**	**(225,000)**	**(475,000)**
All amounts from State General Fund				

Caps, controls, and oversight of the fund. The Medicaid Reinvestment Fund would provide a mechanism whereby the Agency could use net savings from previous investments (as in the first example above) to support advance funding for initiatives that take more than a year to pay for themselves (as in the second example), while yielding total net savings to the state. This mechanism would require controls to ensure agreement on how savings would be identified and how much money could be reinvested into program management. A logical control would be to cap the amount allowed into the fund for use, e.g., at $3-5 million. Or, the Legislature could require a minimum level of cumulative net savings be realized and deposited back into the State General Fund, e.g., $1 million net savings by the end of the third year, $2 million in the fourth year, etc. The Legislature may also wish to place a cap on the number of state FTE supported through the fund, or to prohibit the funding of FTEs altogether (i.e., leaving MRF monies to support outsourced investments only). As a separate fund, the Medicaid Reinvestment Fund would be subject to annual appropriation and included in the budget submission to the Governor. Our conception of the fund is that it would be appropriated through the Consensus Caseload process, ensuring oversight and review by both the Governor's budget staff and legislative staff.

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KANSAS HEALTH POLICY AUTHORITY

February 26, 2010

Senator Jim Barnett
Chair, Senate Public Health and Welfare
Room 234-E

Dear Senator Barnett,

On February 3, 2010 we provided Senate Public Health and Welfare with information about KHPA's current management of controlled substances and diversion of prescriptions in the Medicaid program. This week you asked for an update on the administrative actions KHPA would be taking to address some of the outstanding issues identified in our earlier responses. We address three outstanding questions below:

- imposition of new limits on individual narcotic prescriptions,
- development of limitations for multiple narcotic prescriptions, and
- dispensing narcotics prescribed by providers who do not participate in Medicaid.

Imposition of new limits on individual narcotic prescriptions

The Kansas Medicaid Program has limitations on some narcotic prescriptions, and will be adding additional restrictions based on the recommendations of the DUR Board during their 1/13/10 meeting. Limitations are based on a combination of FDA recommendations, American Pain Society Guidelines, and the clinical experience and expertise of the DUR Board members.

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.

Proposed Limitations

Rm. 900-N, Landon Building, 900 SW Jackson Street, Topeka, KS 66612-1220
www.khpa.ks.gov

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

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

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

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

Implementation of the "proposed limitations" outlined in the chart above and in the dosing comparison chart (below) provided to Ways and Means must occur through KHPA's policy process. KHPA is aware of the legislative interest in this area, and imposition of these limitations has been given a high priority for completion. Additional limitations, primarily for long-acting narcotics, will be discussed at the April DUR Board meeting and will be placed on priority for completion if approved.

Comparison of FDA Recommendations, American Pain Society Recommendations, and Current/Proposed DUR Board Limitations for Oral Opiod Analgesics (Facts and Comparisons ® Classification)

Medication	FDA Maximum Recommended Daily Dose (FDA MRDD)[1] for a 60kg adult	Monthly equivalent	Journal of Pain High-Dose Recommendation (morphine equivalents)[2]	Monthly equivalent	Current limitations (mg/month)	Proposed limitations (mg/month)
hydrocodone	45	1350	200	6000	1350 (hyd/ibu)[3]	6000
oxycodone	319.8	9594	133	3990	14000 (L.A.)[4]	3990
hydromorphone	24	720	50	1500	1440	1500
meperidine	15	450	2,000	60000	36,000	
tramadol	6.67	200.1	6,000	180000	12,000	
propoxyphene	6.5	195	1,200	36000	11,700	
codeine	360	10800	1333	39990		39990
morphine sulfate	100.2	3006	200	6000		6000
oxymorphone	9	270	67	2010		2010
levorphanol	9	270	26.7	801		
methadone[5]	30	900	26	780		
tapentadol[6]						

Development of limitations for multiple narcotic prescriptions

Kansas Medicaid dosing limitations are not currently set up to flag use of high dosages of multiple narcotics. This is a functionality we hope to obtain with the purchase of an automated prior authorization system. Current dosing limitation are able to flag high dosages of acetaminophen or aspirin when the individual is taking more than one combination product (for example, the acetaminophen content in oxycodone and acetaminophen [Percocet] and hydrocodone and acetaminophen [Lortab] will count against each other if filled by the same individual). The Governor's budget recommendations for FY 2011 include an assumption that

KHPA will purchase and implement an automated prior authorization system. However, the recommendations do not include a source of funding for that system. The system would pay for itself through lower Medicaid caseload costs during FY 2011, partly because KHPA has begun the early stages of procurement for the system and will be ready to rapidly complete the process when funding is available. KHPA recently presented to the Senate Ways and Means Committee that would use limited amounts of savings in caseload costs to fund investments in the administration of the Medicaid program. Our proposal would be to use that mechanism, which would require legislative approval, to fund automated prior authorization in FY 2011, which would enable implementation of limitations on multiple narcotic prescriptions.

Dispensing narcotics prescribed by providers who do not participate in Medicaid

Restriction of narcotic prescribers to only providers enrolled in Medicaid is undergoing review. We are pursuing Identification of the specialty and location of the non-enrolled providers through the National Provider Identifier database to access potential impact on beneficiary access to certain types of prescribers and to prescribers in remote areas of the state.

Comments and Clarification Regarding the HMO Privilege Fee

Presented By: Bob Finuf, CEO, Children's Mercy Family Health Partners

March 3, 2010

The following information is provided by Bob Finuf on behalf of CMFHP and UniCare of Kansas. CMFHP and UniCare are the two physical health MCOs that are newly subject to the HMO Privilege Fee under K.S.A. 40-3213 as a result of the revocation of the exemption to the fee by the Insurance Commissioner. The comments and clarification provided below are with regard to the information provided in the report, "Kansas Health Policy Authority Medicaid Savings Options" presented to the Kansas Legislature March 1, 2010. It is our intent to provide our perspective regarding the proposal our organizations, along with Value Options, put forth to KHPA and the portrayal of that proposal in the aforementioned report.

Summary Section, Page 28

Bullet 4: The report contains the following statement, *"The privilege fee which will be assessed on calendar year 2009 and paid by the MCOs on March 1, 2010 will generate $3.1 million in additional new federal funds which could assist in closing the FY2010 budget gap."* We wish to clarify this statement. **The $3.1 million figure stated is the amount of additional state funds available, not federal funds as stated in the report.** The privilege fee payable on March 1, 2010 will generate $4.1 million in new revenue. KHPA will implement the increased payments to the MCOs on April 1, 2010 to begin the recoupment of the fee. The $3.1 million figure mentioned in the report is the amount of funds generated by the fees that are in excess of the increased payments made to the MCO's for the balance of FY10. In other words, since there are only three months left in FY10, and the increased payments are based on spreading the amount of the fee paid prospectively over 12 months, the increased payments will only allow the MCOs to be paid for three of the 12 months of fees paid (about $1 million of the $4.1 million in fees paid by the MCOs) for CY10. If used within the Medicaid program these additional state funds could draw additional federal match.

Spending Options Section, Page 29

Spending Options 1: Bullet 3: The report states as follows, *"Widens the rate discrepancy between providers in the FHP MCO network, UniCare network, and Medicaid FFS providers. FHP would raise rates the most, UniCare second, and FFS providers none at all."* We wish to provide the following comments and clarification regarding our proposal and the impact on provider rates:

1) We agree that there are differences between payment rates between CMFHP, UniCare, and FFS and we believe these exist for good reason. The reasons for these differences are related primarily to CMFHP and UniCare being private contractors, that is, CMFHP and UniCare compete within our provider networks and negotiate with individual providers and systems for payment levels. Therefore there are inherent differences in these private market negotiated rates of payment. As competitors we are not aware of the rates paid to providers by each of our respective companies. We can not therefore determine the specific differences in our level of payments.
2) We do not agree with the statement that (our proposal to pass through the matching federal funds) would result in *"CMFHP raising rates the most and UniCare second"*, or that such increases should they occur as stated would materially change the relativity of current payment levels between CMFHP and UniCare. In other words, we do not know the current relativity of our payment rates, therefore the impact this proposal would have on that relativity is unknown. Further, this report contemplates only the impact of the pass through of the funds related to the proposal and no other payment initiatives that may be under consideration by CMFHP or UniCare and that may be implemented concurrent with this proposal or subsequently.

Spending Options 1, Bullet 4: The report states as follows: *"Creates an uneven playing field between the two MCOs since UniCare would not make as much of an additional commitment to provider rate increases."* As stated above, this report contemplates only the impact of the pass through of the funds related to the proposal. The "playing field", would not be unduly impacted by this proposal as provider payment rates are determined individually by each MCO based on their business decisions and market factors. This proposal is just one factor in the determination of payment rates.

The important point that we wish to reiterate is that **the Medicaid HMOs guarantee that 100% of the amounts paid to them through the increased capitation in excess of the assessed fees, i.e. the federal match, will be passed through to providers.** None of the federal match is retained by the MCOs.

Discussion Points for HMO Privilege Fee Proposal
Presented to KHPA by Bob Finuf, CEO of Children's Mercy Family Health Partners
On behalf of the Medicaid HMOs (CMFHP, UniCare, and Value Options)
Presented: February 19, 2010
Updated: March 3, 2010

1. The historic exemption for Medicaid HMOs (as granted by the Insurance Commissioner) was revoked effective March 1, 2010 and the HMO Privilege Fee is now levied on the Medicaid HMOs.

2. All three Medicaid HMOs (CMFHP, Unicare, and Value Options) are willing to be assessed the fee at the 1% level.

3. Proposal includes a statute change in current HMO Privilege Fee K.S.A. 2009 Supp. 40-3213 to eliminate the "ramp up" period for new HMOs and maximize the assessment. The statute change has been introduced under HB 2723 and SB 560.

4. Proposal includes increasing capitation payments to the Medicaid HMOs to maximize federal matching funds

5. FY 10 will have excess fees assessed but not reimbursed to the HMOs through the increased capitation in the amount of approximately $3.1 million dollars due to the limited remaining months of FY 10 to increase the capitation and the full assessment of the fee paid in CY 2010. Proposal assumes the use of the unreimbursed fees within Medicaid to maximize federal matching funds.

6. Proposal is to use the proceeds from the fees and related increased capitation, and the opportunity to maximize federal funds, to partially restore (or partially avoid) cuts in provider reimbursement by passing those funds through the HMOs. The use of these proceeds can begin in FY 10.

7. HMOs will guarantee as part of the proposal that 100% of the amounts paid to them through the increased capitation in excess of the assessed fees i.e., the federal match will be passed through to providers.

8. Proposal assumes that the net impact on providers and the state is as follows: At its full potential (1%) and assuming flat revenues through FY 12 the fees will generate approximately $4.1 M in new SGF per year which will generate approximately $9 M in additional federal match per year for a total of approximately $27 M for FY 10 – FY 12 available for distribution to providers to restore or avoid the cuts.

Kansas Insurance Department
Sandy Praeger, Commissioner of Insurance

February 25, 2010

The Honorable Mark Parkinson
Kansas State Governor
2nd Floor, State Capitol
300 SW 10th Ave.
Topeka, KS 66612-1590

The Honorable Stephen Morris
Kansas State Senate President
State Capitol, 333-E
300 SW 10th Ave.
Topeka, KS 66612-1590

The Honorable Mike O'Neal
Kansas State House Speaker
State Capitol, 370-W
300 SW 10th Ave.
Topeka, KS 66612-1590

Dear Gentlemen:

For many years, Kansas has imposed a fee on Health Maintenance Organizations (HMO's) for the privilege of operating in the state. See K.S.A. 40-3213. The fee (up to one percent) is imposed against premiums or subscription charges of such HMO's reported by the HMO in the required annual report. The statute grants the Commissioner of Insurance authority to waive the privilege fee in instances where the fee might "cause a denial of, reduction in or elimination of federal financial assistance to the state or to any health maintenance organization subject to this act." For this reason, previous Commissioners and I have waived the fee for HMO's contracting for Medicaid and SCHIP services with the state of Kansas.

It is my understanding that the federal government will allow such fees to be charged to Medicaid and SCHIP HMO's where appropriate arrangements have been made to prevent the "denial, reduction or elimination" of federal assistance. In light of the current budget issues facing the state, I am hereby imposing the operation of the privilege fee on Medicaid and SCHIP HMO's effective immediately. Should it be determined that appropriate arrangements have not been made and that the imposition of such fee will be detrimental to the Medicaid program or the HMO's providing services, I will again be forced to terminate the operation of the privilege fee against such HMO's as authorized by law.

It is my expectation that the privilege fee will be imposed in FY 2010 based on premiums and surcharges of the affected HMO's and will be due upon filing of the annual report. Funds derived from the imposition of this fee shall be deposited in the state general fund in accordance with law this year and all subsequent years. See K.S.A. 40-3213(e).

Please feel free to contact me if you have any questions or concerns about this action.

Sincerely,

[SIGNED]
Sandy Praeger
Commissioner of Insurance

cc: Duane Gossen, Director of the Division of Budget
Andy Allison, Executive Director of Health Policy Authority