

Report of the Special Committee on Medicaid Expansion to the 2020 Kansas Legislature

CHAIRPERSON: Representative Brenda Landwehr

VICE-CHAIRPERSON: Senator Gene Suellentrop

OTHER MEMBERS: Senators Molly Baumgardner, Ed Berger, Barbara Bollier, and Ty Masterson; Representatives Will Carpenter, Jim Kelly, Monica Murnan, Troy Waymaster, and Kathy Wolfe Moore

STUDY TOPIC

The Committee is directed to:

- Study the issues and options surrounding the subject of Medicaid expansion; and
- Receive a report from the Senate Select Committee on Healthcare Access regarding solutions to improve access to healthcare in Kansas.

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Special Committee on Medicaid Expansion

REPORT

Conclusions and Recommendations

Following discussion, the Special Committee on Medicaid Expansion makes the following recommendations and requests:

- The Committee makes no recommendations as to the Senate Select Committee on Healthcare Access (Senate Select Committee) bill draft 20rs1873, but requests it be included in the Committee report along with changing the final word of New Section 5(a) (1) to replace “or” with “and” between phrases describing requirements for eligibility, as was the stated intention of those requesting the bill draft. The final report of the Senate Select Committee is attached for reference;
- The Committee requests the Kansas Department of Commerce:
 1. Initiate a rural health care task force similar to the model established in Tennessee, in order to investigate health care issues in rural Kansas; and
 2. Provide data on the Reemployment Services and Eligibility Assessment program for the past five years and data on other programs offered by the agency under KANSASWORKS;
- The Committee requests the Kansas Hospital Association:
 1. Develop a transparency plan to analyze any current cost shifting to commercial insurance plans and to measure uncompensated care on an allowable, not a gross, charge perspective net of disproportionate share hospital (DSH) payments;
 2. Provide patient census information and services for those hospitals in Kansas that have a daily average of ten or fewer patients; and
 3. Provide information related to the hospital surcharge considered in the Senate Select Committee bill draft 20rs1873 and any considerations related to the timeline for collection of such surcharge;
- The Committee recommends the Kansas Department of Health and Environment (KDHE) correspond with the federal Centers for Medicare and Medicaid Services (CMS) to inquire whether CMS would consider a reinsurance program under a Section 1332 waiver in conjunction with a Section 1115 waiver to meet federal budget neutrality requirements;
- The Committee requests KDHE provide:
 1. Information on the DSH payments to each hospital for the previous three calendar years; and
 2. A separate fiscal note related to the number of children that would potentially join the Medicaid program if their parents become eligible;

- The Committee requests the Department for Children and Families provide information related to high school graduation rates of foster care children over the past ten years and the programs and partnerships, other than the Jobs for America’s Graduates-Kansas program, currently used to provide services to foster care children;
- The Committee recommends any Medicaid expansion considered by the Legislature contain a provision to:
 1. Prohibit coverage or reimbursement for any abortion services beyond those currently provided in Medicaid and in the Children’s Health Insurance Program (CHIP);
 2. Include religious and professional conscience protections for healthcare institutions and individuals;
 3. Require 20 hours of work per week or 12 college credit hours per semester;
 4. Waive premiums for persons with severe mental illness (SMI) or families with a child with a serious emotional disturbance (SED);
 5. Provide an exemption for lockout from the Medicaid program for persons with SMI or families with a child with SED;
 6. Waive premiums for persons with severe, chronic, life-limiting illnesses; and
 7. Provide an exemption from lockout from the Medicaid program for persons with severe, chronic, life-limiting illnesses; and
- The Committee requests the Legislative Coordinating Council approve one additional meeting day per quarter for the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight to monitor Medicaid expansion and review requested reports, including those on payments made to hospitals, pathways to work, budget projections, and health outcomes.

Proposed Legislation: None

BACKGROUND

The Special Committee on Medicaid Expansion was created by the Legislative Coordinating Council (LCC) to study the issues and options surrounding the subject of Medicaid expansion. The Committee was authorized to meet for two days.

COMMITTEE ACTIVITIES

The Committee met November 12 and 13, 2019. In accordance with its study topic, the Committee’s work focused on the testimony and topics described in the following sections.

Access to Care Considerations

The Committee received presentations from stakeholders related to access to care. Topics included the coverage gap, the multiple waiver approach and timeliness of implementation, financially at-risk hospitals, alternative models of care, uncompensated care, premiums and co-pays for enrollees, the proposed provider tax, the Federal Medical Assistance Program (FMAP) and poison pill provisions, and mental health services.

Coverage gap. The Senior Vice President, Government Relations, Kansas Hospital Association (KHA), stated KHA is concerned some Kansans earn too much to qualify for KanCare, but too little to receive financial

assistance to purchase private insurance on the individual Health Insurance Marketplace (commonly referred to as the “coverage gap”).

Multiple waiver approach and timeliness of implementation. The KHA representative discussed alternatives beyond traditional Medicaid expansion under consideration, stating that including an implementation date of January 1, 2021, would maximize access to healthcare coverage and ensure the multiple waiver approach does not effect the timeliness of expansion.

The Executive Director, Association of Community Mental Health Centers of Kansas (ACMHCK), stated ACMHCK is concerned with the timeliness of the waiver submission processes that could obstruct the implementation of expansion by January 1, 2021. He stated timeliness of the waiver is a pressing concern because it could affect workforce provider recruitment and retention.

At-risk hospitals. The KHA representative noted 29 hospitals in Kansas were considered to be financially at-risk, and 85 percent of Kansas hospitals have negative operating budgets.

Alternative models of care. The KHA representative stated the Primary Health Center (PHC) model for rural hospitals is a proposed mechanism to adapt the service model, payment method, and focus of outpatient and emergency service needs. The model is intended to close gaps between a rural health clinic and a federally qualified health center, and is intended to assist rural communities that cannot sustain the current health care delivery model. He stated a demonstration proposal for a PHC model could be submitted and approved by the Centers for Medicare and Medicaid Services (CMS) by the end of 2019, and would assist KHA in developing strategies to address workforce issues and provider assessment resources in hospitals.

Uncompensated care. The KHA representative stated uncompensated care has been reduced by 35 percent to 45 percent in other states that have expanded Medicaid. Uncompensated care is a combination of services provided to uninsured patients and the shortcomings in the Medicare and Medicaid payment rates. Financially at-risk hospitals would have access to additional

federal funds for the expansion population, he stated, and thus would have additional resources to improve responses to challenges. The estimated increase in expansion revenue would fund additional staff, local services, or equipment, and could reduce the local tax revenue provided to support operations of some hospitals.

Premiums and co-pays for enrollees. The KHA representative noted premiums and co-pays assessed to expansion enrollees could pose costly administrative challenges, as well as potential financial barriers for low-income individuals. He stated lockouts, premiums, and co-pays expend provider resources and cost more to administer than the value of their collection. He stated KHA would have concerns with a permanent lockout and would like to see a simplified version of the program that avoids barriers to individuals.

The ACMHCK representative noted the premium assistance program and lockout process is of concern. He noted the waxing and waning of an individual’s mental health illness affects his or her ability to work and would be affected by a lockout. He noted the proposed Senate bill does not include the ability for clinical judgment in regard to a lockout. If included in legislation, ACMHCK would be willing to work with the Kansas Department of Health and Environment (KDHE) or the Kansas Department for Aging and Disability Services (KDADS) to facilitate a safety net assistance program for individuals who have a mental illness that could affect employment and payment of premiums.

According to the Deputy Medicaid Director, KDHE, lockouts currently apply only to the Children’s Health Insurance Program (CHIP) because premium payments apply only to this population. KDHE contracts for the collection of CHIP payments, with an approximate 30 percent to 35 percent delinquency rate, meaning individuals move in and out of the program due to nonpayment of premiums.

Provider tax. The KHA representative stated the proposed provider tax provision, an additional potential revenue source for Medicaid expansion, would place an additional financial burden on medical providers and must be fair and equitable.

FMAP and poison pill provisions. The KHA representative expressed support for the bill draft's FMAP Stabilization Fund provision, as well as the "poison pill" to end the Medicaid expansion program if the federal share of payments drops below 90 percent.

The ACMHCK representative noted support for the FMAP Stabilization Fund concept.

Mental health. The ACMHCK representative provided an overview of current mental health center challenges and the potential effect of Medicaid expansion on mental healthcare. He noted a survey of the five community crisis centers in operation indicated an estimated 75 percent of patients lack any payer source. Medicaid expansion would provide individuals in the coverage gap access to additional health services, while decreasing providers' rates of uncompensated care. Additionally, Medicaid expansion would have a significant impact on the State's workforce provider recruitment and retention rates. The significant pay differential between Kansas and surrounding states that are receiving additional federal funds has created a workforce retention problem. Many mental health professionals are recruited away from Kansas to surrounding states, resulting in a workforce shortage of psychiatrists, nurse practitioners, and clinicians. Additional funds from expansion could be used by mental health centers to refocus efforts on retaining and recruiting a workforce to meet the 21 percent increase in crisis intervention services. Additional funding from Medicaid expansion could also be used for innovation training and research purposes. Compared to surrounding states, Kansas has some of the highest credentialing standards in the nation. Aligning Kansas' credentialing standards closer to the national average would promote a more robust workforce.

Overview of the Individual Health Insurance Market

The Director of the Health and Life Division, Kansas Insurance Department (KID), presented an overview of Kansas' Federally Facilitated Marketplace (FFM), noting since Kansas does not have a state-based exchange, KID sends a data call each year to insurance carriers in order to gather information about types of coverage offered by

those carriers. She stated 82 types of individual policies were being offered for 2020 by 5 health insurance companies on the FFM in Kansas. She also noted Advance Premium Tax Credits are offered to individuals who do not exceed certain income thresholds shopping on the FFM.

The Director of Government Affairs and Communications, KID, provided information on Section 1332 and Section 1115 waivers, noting KID would have to ask the U.S. Department of Health and Human Services (HHS) whether the FFM is set up to function in a manner contemplated by the draft Senate bill. [Note: The language of the bill draft would direct KID to apply for the Section 1332 waiver to offset the cost of the Section 1115 waiver.] The KID representatives noted there is no process to address fiscal notes on a "revisor's draft," so fiscal information is not available. Upon a formal bill introduction, the Division of the Budget (DOB) would issue a cost request to KID in preparation for a fiscal note.

The Director of Government Affairs and Communications stated counsel for KID believes the agency cannot prepare a request for proposal (RFP) for a Section 1332 waiver because the agency does not have the statutory authority to do so. Assuming the Legislature authorizes and directs KID to apply for the Section 1332 waiver and after KID either amends an actuarial contract or submits a new RFP for the actuarial work, it would likely be six months before the waiver application could be submitted to CMS. The representatives also noted the cost to prepare a Section 1332 waiver could be a few million dollars, and requested the Legislature appropriate moneys for this process.

An invited member of the Senate Select Committee on Healthcare Access (Senate Select Committee) noted a fiscal note would be approximately \$150,000 since KID does not have experience with Section 1332 waivers.

Overview of State Innovation

A senior analyst for the Kansas Health Institute (KHI) provided information on Section 1332 of the Patient Protection and Affordable Care Act, which provides the authority for Section 1332 waivers. A Section 1332 waiver allows a state to

apply to HHS for a waiver to develop and implement state-specific approaches and strategies to health reform and coverage. Once approved, she stated, a Section 1332 waiver may remain in effect for five years and be extended. She noted a Section 1332 waiver is not related to Medicaid and is intended to implement programs that will impact the state's private health insurance market. She noted states have been encouraged by CMS to submit Section 1332 waivers to address the cost of individual health insurance markets and to consider implementing a high-risk pool or state-operated reinsurance program.

The KHI senior analyst provided additional information on reinsurance programs, noting these programs can help stabilize the market and reduce premiums by reimbursing insurers for some portion of their incurred claims for high-cost enrollees. She stated a waiver is considered budget neutral if the state's premiums offset the federal tax credits. The state can receive pass-through funding to help fund the cost of implementing the state waiver or reinsurance program if the state's approved waiver results in savings to the federal government. She noted a state may submit a single coordinated waiver application under Section 1332 and under other existing waiver processes (*e.g.*, Section 1115), which are evaluated independently according to applicable federal law.

Update on *Texas v. United States* Lawsuit

The Office of the Attorney General provided written-only testimony regarding the *State of Texas, et al. v. United States of America, et al.* in the U.S. Court of Appeals for the Fifth Circuit. The case involves the collection of health insurance provider (HIP) fees assessed against companies that manage state Medicaid or CHIP programs.

Presentation on Senate Select Committee on Healthcare Access Information

The Committee was provided with a draft report (Appendix A) and reviewed the recommendations of the Senate Select Committee, as well as Senate bill draft 20rs1873. [*Note:* The Senate Select Committee met October 22 and 23, 2019, and considered solutions to improve access to healthcare in Kansas.]

An Office of Revisor of Statutes staff member compared provisions in the Senate bill draft 20rs1873 to 2019 HB 2066 on an issue-by-issue basis. He specified no current provisions in Kansas statutes establish a health insurance premium assistance program similar to that considered by New Section 5 of proposed Senate bill draft 20rs1873 and, under LCC Policy 33, committees are prohibited from sending correspondence to the congressional delegation without prior authorization from the LCC.

The Committee members and the invited Senate Select Committee member discussed a change to Section 5 of bill draft 20rs1873, to replace “or” with “and” in subsection (a) between phrases describing requirements for eligibility, as was the stated intention of those requesting the bill draft; noted other states have used a similar approach to charging a co-pay in circumstances described as non-urgent emergency care, as found in New Section 4; and discussed the FMAP provisions of the Senate bill draft and 2019 HB 2066. The invited Senate Select Committee member clarified the intent of provisions of Section 12 of the bill draft.

A Committee member also drew the Committee's attention to the Minority Report of the Senate Select Committee.

FMAP Stabilization Fund

The Assistant Revisor provided information on the mechanics of the FMAP Stabilization Fund bill, 2019 SB 2, during his comparison of 2019 HB 2066 and the Senate bill draft. The FMAP determines the state and federal shares of funding for Medicaid, adoption assistance, foster care, and child care, and it is based on a three-year average of per capita personal income for state residents as compared to the national average. If a state experiences per capita personal income growth higher than the average rate for other states, the state's FMAP score could decrease; a state with a lower per capita personal income growth rate could see an increase in its FMAP score. An invited member from the Senate Select Committee stated he was not aware of other states that had established an FMAP Stabilization Fund, and he noted the significant impact a change in the FMAP can have on the state budget.

Comments on Medicaid Expansion

The Committee received comments from a representative of the Alliance for a Healthy Kansas (Alliance), and written-only comments from other stakeholders.

Coverage gap. The Alliance representative provided testimony to the Committee regarding individuals in the health insurance coverage gap. She noted the majority of individuals in the coverage gap (64 percent) are working, but they do not have insurance through their work due to the high cost of premiums, or because it is not available through the employer.

Premiums and lockouts. The Alliance representative stated administrative flexibility should be provided for in a bill in order to prevent loss of coverage for consumers facing catastrophic illnesses. She noted premiums and lockouts would create barriers to participation for low-wage earners. Although individuals at 100 to 138 percent of the federal poverty level (FPL) are eligible to purchase insurance on the exchange with subsidies, many are still unable to afford their premiums.

Work requirements. The Alliance representative stated work requirements are administratively costly and another barrier to participation. Persons working in low-wage jobs do not necessarily have control over the number of hours worked, and a reduction in work hours by the employer could result not only in a loss of income but also health insurance. She noted states have yet to find a work requirement formula that benefits the state. If the work referral provision is implemented, she stated, the process should be as seamless and streamlined as possible for beneficiaries to comply.

Economic benefits. The Alliance anticipates within the first full year of expansion, approximately 13,400 new jobs would be added, and between \$31 million and \$38 million in new sales and income tax revenue would be generated.

Timeliness of expansion. The Alliance representative stated, in order to expedite the Medicaid expansion process and extend coverage to low-income Kansans, Alliance prefers a straight expansion of Medicaid. The preparation and

approval process of additional waivers can create significant delays. She stated a bifurcated process that allows for implementation of expansion through a State Plan Amendment at the same time the waiver process is under way would expedite expansion processes.

The Vice-chairperson noted the essential nature of having the Section 1332 waiver in place from the start, stating the value of the Section 1332 waiver is the potential 20 percent reduction in rates on the exchange, which would allow more individuals to buy insurance. Allowing individuals with incomes between 100 and 138 percent of FPL to remain on the exchange with private carrier coverage is a significant piece of bill draft 20rs1873.

The Secretary of Health and Environment stated the Section 1115 and Section 1332 waivers would have to achieve budget neutrality on their own without relying on each other.

Written-only testimony from individuals, providers, and organizations. A private citizen and representatives of the following organizations provided written-only testimony: AARP, American Academy of Pediatrics, American Cancer Society, American Heart Association, American Lung Association, Behavioral Health Association of Kansas, Children's Alliance of Kansas, Community Care Network of Kansas, Community Health Center of Southeast Kansas, GraceMed, Health Forward Foundation, Health Partnership Clinic, InterHab, KanCare Advocates Network, Kansas Action for Children, Kansas Advocates for Better Care, Kansas Association of Community Action Programs, Kansas Catholic Conference, Kansas Coalition Against Sexual and Domestic Violence, Kansas Farmers Union, Kansas Interfaith Action, Leukemia and Lymphoma Society, Midwest Cancer Alliance Partners Advisory Board, National Multiple Sclerosis Society, Oral Health Kansas, Overland Park Chamber of Commerce, Planned Parenthood, Salina Family Healthcare Center, Susan G. Komen Kansas and Western Missouri, REACH Healthcare Foundation, and The Whole Person.

Overview of KANSASWORKS, Workforce System, and Barriers to Work

The Legislative Director, Kansas Department of Commerce, provided an overview of the KANSASWORKS program. He noted KANSASWORKS links businesses, job candidates, and educational institutions to ensure employers find skilled workers. He stated employment services are offered at 27 workforce centers, online or virtually, and at mobile workforce centers. Intensive training, specialized placement, and job location assistance programs are available to potential workers of all ages and employment needs. He noted KANSASWORKS programs are federally funded with no state matching funds. To equip the agency to handle an influx of new participants, the Legislative Director advised an increase in funding to improve its website and hire additional staff. He stated salaries plus benefits would be approximately \$50,000 per employee, and the cost for website improvements could range from \$50,000 to \$100,000, depending on restructuring needs.

Medicaid Expansion Outcomes

The Executive Director, Kansas Association of Medicaid Health Plans (KAMHP), provided written-only testimony. KAMHP is a non-profit organization composed of three managed care organizations (MCOs) with active contracts serving the KanCare Medicaid population. The MCOs serve 400,000 Medicaid enrollees and are prepared to serve the additional 150,000 should Kansas decide to expand Medicaid eligibility. The testimony noted the MCOs incentivize KanCare members to work by addressing health and social needs that often stand in the way of individuals actively participating in the workforce. To promote healthy behaviors, each MCO has value-added benefits that reward and incentivize healthy behaviors.

Medicaid Expansion in Other States

The Government Affairs Director, Foundation for Government Accountability (FGA), provided an overview of the benefits the State currently offers, as well as expansion experiences in other states. He stated Kansas' estimation of 130,000 new enrollees is dramatically underestimated because, nationally, more than twice as many adults signed up than originally anticipated, with

per-person costs 76 percent higher than initially predicted by CMS. He stated, given enrollment trends from states that have expanded Medicaid coverage, a more accurate enrollee number could exceed 250,000. He expressed concerns Medicaid expansion would siphon resources from those already enrolled in the Medicaid program and CHIP; expansion could take away an individual's choice of insurance coverage provider and drive up hospital operating costs, as Medicaid consumers covered at lower reimbursement rates would increase; and the Committee should consider work requirements.

The Vice President for Financial Advocacy, KHA, stated there are twice as many people without coverage and for whom hospitals do not expect to recoup any payment for services rendered. Private coverage deductibles have become so high that individuals cannot afford to pay the deductibles, resulting in bad debt for hospitals.

Tobacco Tax Collections

The Director of Research and Analysis, Kansas Department of Revenue (KDOR), provided information regarding the three different excise taxes on tobacco or smoking products: cigarettes, other tobacco products, and consumable materials. A brief history of each tax was provided, with graphs and tables reflecting changes in the tax rates over time.

The Director noted in fiscal year (FY) 2021, KDOR estimated if the price for a 20-pack of cigarettes increased by \$0.50, \$1.00, or \$1.50, the additional revenue would be \$31.3 million, \$53.14 million, or \$66.66 million, respectively. For FY 2021, assuming the tax of cigarettes remained at \$1.29 for a 20-pack of cigarettes and the consumable material tax increased to \$0.43/ml, \$0.65/ml, or \$1.29/ml, the revenue increase is estimated to be \$7.9 million, \$12.42 million, or \$25.34 million, respectively. If the tax for a 20-pack of cigarettes increased by \$1.00 and the consumable material tax increased to \$0.76/ml, \$1.15/ml, or \$2.29/ml, the estimated revenue for FY 2021 would be \$14.67 million, \$22.55 million, or \$44.84 million, respectively.

Fiscal Implications of Medicaid Expansion Proposals

The Director of the Budget provided a briefing of the fiscal impact of Medicaid expansion. The fiscal numbers are calculated by the state agencies and analyzed by analysts at the Division of the Budget. Enactment of 2019 HB 2066 would result in additional expenditures of \$33.9 million from the State General Fund (SGF), with a range of \$34 million to \$38 million for ongoing costs. The estimate included the federal match, prescription drug rebates, managed care privilege fees, and shifts within the Medicaid population that will generate cost savings. The estimate did not take into account the offsets generated by economic growth or the approximately \$3 million in savings within the Kansas Department of Corrections (KDOC).

The Director noted Senate bill draft 20rs1873 was more difficult to assess given the complex nature of the proposal. He stated financial risk factors related to bill draft 20rs1873 include an unknown price tag, no definitive pay-for, and greater financial risk associated with complex policies. If Kansas were to expand to 100 percent FPL and not receive enhanced funding, this would cost the State \$221 million more than full expansion while covering 50,000 fewer lives. KDHE has estimated administering premiums would require around 2,700 hours of system changes, costing about \$325,000. The agency estimated ongoing administrative costs to be around \$2 million. The Director noted administrative “add-ons” are not eligible for the enhanced federal match. Tiered benefit plans with enhanced benefits for individuals who demonstrate healthy behaviors would require around 1,300 hours of system changes and cost roughly \$156,000 for the state system.

An independent analysis provided by KHA indicated a simple Medicaid expansion proposal could create more than 13,000 new jobs by 2021 and produce annual tax revenues of approximately \$30 million beginning in FY 2023.

Overview of Current Medicaid Program and Expansion Proposals

The State Medicaid Director, KDHE, provided an overview of the current Medicaid program in Kansas, populations and services covered, and

program expenditures. KDHE sets the guidelines and eligibility policies for Medicaid under the State’s current Section 1115 waiver and is the primary contact with CMS. He noted a state’s Medicaid expansion plan must provide coverage for ambulatory patient services, emergency services hospitalization, pregnancy, maternity and newborn care, mental health and substance abuse disorder services, prescription drugs, rehabilitative and habilitative services, and pediatric services.

The State Medicaid Director noted current eligibility guidelines state a Medicaid applicant must be at least 18 years old, or a guardian, conservator, or both, and a resident of Kansas. Income thresholds vary depending on classification category. Regardless of income, current Medicaid guidelines do not provide coverage options for childless adults. Parents, guardians, or both are eligible for Medicaid when income is at or below 38 percent FPL. Eligibility for the Medicaid program is reviewed annually.

The State Medicaid Director stated the federal financing component of Medicaid was based on the following key assumptions from 2019 HB 2066: 150,000 newly eligible adults, a \$625 per member per month capitation payment, and offsets to reduce the total cost. He noted only KDHE’s budget was considered, and other potential economic benefits realized across the state or savings realized by KDOC were not included. After all offsets, the net cost to KDHE is expected to be approximately \$34 million to \$35 million with a 90 percent federal match. The effect of expansion on MediKan and KDOC is expected to result in \$2 million in state savings. Partial expansion without enhanced federal funding would cost the state \$221 million more and cover 50,000 fewer lives.

The State Medicaid Director noted states are required to return 90 percent of premiums collected to the federal government. Accounting for the federal share of the premiums and the administrative cost to operate the program, the impact is expected to be between negative \$900,000 and positive \$900,000.

The State Medicaid Director provided information on the Health Care Access Improvement Program (HCAIP), noting certain hospitals pay a provider assessment tax equal to

1.83 percent of the 2010 net inpatient revenue. These funds bring in about \$47 million per year in state funds, and are matched with federal dollars for a net of approximately \$108.8 million per year. The revenue is dispersed back to hospitals and physicians through various avenues. Revenue from HCAIP is tracked by KDHE and reported to the HCAIP Panel. Pending changes to the HCAIP were provided to the Committee, which include an increase in the provider assessment from 1.83 percent of net inpatient revenues to 3.0 percent net inpatient and outpatient revenues, and a change in the base tax year to 2016. The pending change is estimated to bring in about \$163.6 million from the providers for a total of approximately \$381.5 million from all funding sources, including federal match. He stated increasing the HCAIP fund requires amending the Section 1115 waiver to account for the new moneys in the budget neutrality provision, and requires CMS approval. He stated CMS approval was then being negotiated, and the hospital surcharge proposed in Senate bill draft 20rs1873 would be on top of the current HCAIP.

Overview of Medicaid Demonstration Waivers

The State Medicaid Director reviewed Medicaid and other waivers relevant to Medicaid expansion. He noted the current KanCare program is operated under the authority of a Section 1115 waiver, and has been approved through December 31, 2023. Section 1115 waivers must demonstrate budget neutrality and govern the entire KanCare program. The Section 1915(c), or home- and community-based services, waivers are under the Section 1115 waiver umbrella, and are used to target services to specific populations. He stated states intending to amend provisions of a Section 1115 waiver must provide CMS with 120 days' notice. The anticipated timeline to complete a Section 1115 waiver could be as little as seven to nine months, but is dependent on CMS requirements.

The State Medicaid Director provided information on Section 1332 waivers. He stated the following four “guardrails” must be met in order for the waiver to be approved by CMS: coverage must be as comprehensive as coverage would be absent the waiver, coverage must be affordable, the scope of coverage must be provided to a comparable number of residents, and

there cannot be an increase in the federal deficit. When calculating budget neutrality for either waiver, no potential impact can be assumed, and savings cannot accrue across waiver types; the waivers are standalone applications.

CONCLUSIONS AND RECOMMENDATIONS

The Committee made the following requests and recommendations:

- The Committee makes no recommendations as to the Senate Select Committee bill draft 20rs1873, but requests it be included in the Committee report along with a change in New Section 5(a) to replace “or” with “and” between phrases describing requirements for eligibility, as was the stated intention of those requesting the bill draft. The final Senate Select Committee report is attached for reference;
- The Committee requests the Kansas Department of Commerce:
 1. Initiate a rural health care task force similar to the model established in Tennessee, in order to investigate health care issues in rural Kansas; and
 2. Provide data on the Reemployment Services and Eligibility Assessment program for the past five years and data on other programs offered by the agency under KANSASWORKS;
- The Committee requests the KHA:
 1. Develop a transparency plan to analyze any current cost shifting to commercial insurance plans and to measure uncompensated care on an allowable, not a gross, charge perspective net of disproportionate share hospital (DSH) payments;
 2. Provide patient census information and services for those hospitals in Kansas that have a daily average of ten or fewer patients; and

3. Provide information related to the hospital surcharge considered in the Senate Select Committee bill draft 20rs1873 and any considerations related to the timeline for collection of such surcharge;
- The Committee recommends KDHE correspond with the federal CMS to inquire whether CMS would consider a reinsurance program under a Section 1332 waiver in conjunction with a Section 1115 waiver to meet federal budget neutrality requirements;
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 - The Committee requests the Department for Children and Families provide information related to high school graduation rates of foster care children over the past ten years and programs and partnerships, other than the Jobs for America's Graduates-Kansas, currently used to provide services to foster care children;
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 1. Prohibit coverage or reimbursement for any abortion services beyond those currently provided in the Medicaid program and CHIP;
 2. Include religious and professional conscience protections for healthcare institutions and individuals;
 3. Require 20 hours of work per week or 12 college credit hours per semester;
 4. Waive premiums for persons with severe mental illness (SMI) or families with a child with a serious emotional disturbance (SED);
 5. Provide an exemption for lockout from the Medicaid program for persons with SMI or families with a child with SED;
 6. Waive premiums for persons with severe, chronic, life-limiting illnesses; and
 7. Provide an exemption for lockout from the Medicaid program for persons with severe, chronic, life-limiting illnesses; and
 - The Committee requests the LCC approve one additional meeting day per quarter for the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight to monitor Medicaid expansion and review requested reports, including payments made to hospitals, pathways to work, budget projections, and health outcomes.

APPENDIX A

**Report of the
Senate Select Committee on
Healthcare Access
to the
2019 Special Committee on
Medicaid Expansion**

CHAIRPERSON: Senator Gene Suellentrop

VICE-CHAIRPERSON: Senator Ed Berger

OTHER MEMBERS: Senators Molly Baumgardner, Rick Billinger, Jim Denning, Bud Estes, Anthony Hensley, Dan Kerschen, Ty Masterson, Pat Pettey, Mary Pilcher-Cook, and Mary Jo Taylor

STUDY TOPIC

- Consider solutions to improve access to healthcare in Kansas and report the information to the Special Committee on Medicaid Expansion.

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Senate Select Committee on Healthcare Access

Summary of Conclusions:

The Senate Select Committee on Healthcare Access proposes bill draft 20rs1873 be revised to clarify the premium charged to covered individuals whose income is greater than 100 percent of the federal poverty level would be equal to 5.0 percent of modified adjusted gross income assessed on an individual basis, but the aggregate share cannot exceed 5.0 percent of the modified adjusted gross income of the household, and the revised bill be provided to the members of the Senate Select Committee on Healthcare Access and the Special Committee on Medicaid Expansion.

The Select Committee requests the Office of Revisor of Statutes prepare two memorandums to be delivered to the Special Committee on Medicaid Expansion that compare bill draft 20rs1873, as revised, to pending legislation specified in this report.

To the extent possible under the law, the Select Committee requests and encourages the Kansas Insurance Department to begin work on a Section 1332 waiver.

If the Select Committee is authorized to continue working on 20rs1873, as revised, it is recommended the bill be introduced on the first day possible and referred to the Senate Select Committee on Healthcare Access, and if the Select Committee is not authorized to continue, then the revised bill draft be introduced on the first day possible and referred to the Senate Committee on Public Health and Welfare.

The Select Committee requests the Kansas Department for Aging and Disability Services provide testimony to the committee that hears bill draft 20rs1873, as revised, and to apply for a waiver *via* statute on the Institutions for Mental Disease (IMD) exclusion recommended by the Task Force on Mental Health and also use the guidelines the Centers for Medicare and Medicaid Services (CMS) published in their November 1, 2017, letter to state Medicaid directors on that subject that integrated crisis stabilization centers into the IMD exclusion.

The Select Committee requests the Kansas Hospital Association (KHA) develop transparency plans as specified in this report.

The Select Committee requests the Kansas Department of Commerce to initiate a rural health care task force as outlined in this report.

The Select Committee requests KHA work with the University of Kansas Health System to evaluate applying to CMS for a demonstration project for a modified rural health delivery system.

The Select Committee recommends the Kansas Congressional delegation be asked to improve the fiscal health and modify the delivery system of rural hospitals and providers.

Proposed Legislation: Bill draft 20rs1873, as revised.

BACKGROUND

On May 29, 2019, the Senate President announced the creation of the Senate Select Committee on Healthcare Access (Select Committee), charging it to consider solutions to improve access to healthcare in Kansas and report the information to the Special Committee on Medicaid Expansion. The Select Committee was authorized two meeting days.

COMMITTEE ACTIVITIES

The Select Committee met on October 22 and 23, 2019.

Overview of Current Medicaid Program, Populations Covered, Numbers Served, and Expenditures, including Inmate Coverage Both during and after Incarceration

The State Medicaid Director, Kansas Department of Health and Environment (KDHE), provided an overview of the current Medicaid program, financial estimates on expansion, and waivers.

KDHE maintains the State Plan and has accountability for the Section 1115 waiver. Within federal guidelines and as authorized by state law, KDHE sets the guidelines and eligibility policy for people to apply for Medicaid. KDHE contracts for the Medicaid Management Information System and the Kansas Eligibility and Enforcement System. Three managed care organizations (MCOs) oversee the delivery and payment of healthcare services. KDHE is the primary contact with the federal Centers for Medicare and Medicaid Services (CMS).

Generally, a Medicaid application must be filed, an applicant must be able to act on his or her own behalf (at least 18 years old or a guardian and/or conservator has to apply), either a U.S. citizen or eligible non-citizen, and a resident of Kansas. The applicant must provide all needed information and cooperate with the application process. All persons residing in the household must be included on the application. Financial requirements may vary, depending on which population category one is classified. If the

information has not been received within the statutory guideline of generally 45 days, the process starts over; however, the statutory guideline may be paused under specific circumstances. Requiring the application process to start over is the exception and not the rule because KDHE reaches out to applicants to complete the missing information.

A state's Medicaid expansion plan must include coverage for ambulatory patient services, emergency services, hospitalization, pregnancy, maternity and newborn care, mental health and substance abuse disorder services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive services, and pediatric services.

In Kansas, the applicant must be a resident of the state. Kansas does not provide a Medicaid option for childless adults, regardless of income. Non-pregnant parents and caretakers are eligible for KanCare (the Medicaid managed care program in Kansas) when their income is at or below 38 percent of the federal poverty level (FPL). Since the Federal Health Insurance Exchange does not provide subsidies until one is at 100 percent of FPL, there is a coverage gap in Kansas for those between 38 percent and 100 percent of FPL. Eligibility is granted on an annual basis.

The State Medicaid Director reviewed the process for covering inmates both during and after release. This included releases from prisons, state hospitals, and county jails and discharges from mental health institutions.

Fiscal assumptions. The fiscal impact of one Medicaid expansion bill (2019 HB 2066) assumes:

- 150,000 newly eligible members would equate to a 36 percent increase in the total population, which would be in line with the national average (35 percent) but more than states that have most recently expanded (22 percent). KDHE estimates approximately 80,000 potential members;
- \$625 per member per month (PMPM) capitation payment;

- Offsets, including privilege fees and incremental drug rebates, to reduce the total cost. Also, the Department of Corrections (DOC) would be able to access additional federal funds for the expansion population, resulting in savings; and
- Straight Medicaid expansion, with no additional layers placed on top of the program.

The initial cost for expansion would be approximately \$1.1 billion. After all offsets, the net cost to the State would be approximately \$34.0 million to \$35.0 million. The estimate does not account for savings that could be realized by DOC. Since July 1, 2012, KDHE and DOC have used Medicaid funding to pay for inpatient services when an inmate is in a hospital for more than 24 hours. The inmate must meet all required eligibility criteria and have a qualifying event. Many cases today require presumptive disability determination, but that need would diminish under expansion. Both agencies have dedicated staff to work on these cases.

There is no estimate for secondary economic benefits. If premiums are assessed to the expansion population, states are required to transfer 90 percent of the premiums to the federal government.

The State Medicaid Director also provided a list of guardrails from CMS on proposals that would not be approved based on policy or legal grounds. A financial estimate of “partial” Medicaid expansion was also provided.

Medicaid Waivers: Types, Populations and Services Covered, Submission and Approval Process, and Length of Time to Institute

The State Medicaid Director, KDHE, and a representative from the Kansas Health Institute reviewed Medicaid and other waivers:

- Section 1115 waivers must demonstrate budget neutrality—federal spending cannot exceed what would have been spent in the absence of the waiver. In

KanCare, the waiver is used to mandate most populations enroll in a managed care plan;

- Section 1915(c) or HCBS (Home Community Based Services) waivers must be cost neutral—per capita costs do not exceed average cost of institutional settings. The waivers are used to target services to specific populations; and
- Section 1332 waivers are not considered Medicaid waivers, as they are in a different section of the Affordable Care Act, and have different approval/authority paths than Medicaid waivers. This section of the Affordable Care Act grants no authority to waive anything in Title XIX (Medicaid).

KanCare operates under a comprehensive Section 1115 waiver, which is approved through December 31, 2023. Each of the Section 1915(c) waivers is under the Section 1115 umbrella. These are the HCBS waivers administered by the Kansas Department for Aging and Disability Services (KDADS). Most beneficiaries are required under the waiver to receive all their services through managed care plans. MCOs manage HCBS waiver services along with physical and behavioral health services. More than 100 special terms and conditions (STCs) must be monitored, and quarterly reporting for financial performance and other measures is required.

Straight expansion could be implemented under an amendment to the State’s current waiver, which would include the expansion population and updated calculations showing budget neutrality. Additional layers added to the expansion plan would be handled one of two ways, with the path to approval ultimately determined by CMS. Amendment to the current waiver, including updating budget neutrality, does not require the assistance of a consultant, other than KDHE’s current actuarial vendor. If CMS deems changes to be substantial, they could deem this a new demonstration, which would require a new waiver application and the assistance of a consultant, as well as adding time to the process.

A Medicaid Section 1115 waiver application or amendment cannot assume any potential impact from a Section 1332 waiver submission.

Approval timeline for Section 1115 waivers.

A State intending to amend the provisions of a current waiver must give 120 days' notice to CMS. If a waiver is amended, a State would likely not be required to hold multiple public meetings, though the waiver and corresponding State Plan Amendment would be posted for public comment. The current actuarial vendor for KDHE would recalculate budget neutrality, incorporating new eligibility groups.

New waiver applications have additional CMS requirements, which would likely involve hiring a consultant to assist with the process. For reference, the current KanCare waiver renewal application took approximately 22 months to complete.

State Innovation (Section 1332) Waivers

According to the State Medicaid Director, most states have used 1332 waivers for reinsurance on the insurance exchange. Nearly every state grants authority to a state insurance agency to file and administer the waiver. Generally when granted, this waiver leverages federal savings, which are then passed through to fund program. There are four guardrails to be met in order for the waiver to be deemed complete. Coverage must be as comprehensive as coverage would be absent the waiver. Coverage must be affordable. The scope of coverage must be provided to a comparable number of residents, and there cannot be an increase in the federal deficit.

When calculating budget neutrality for either waiver, the assumptions of the base and waiver must be separate and distinct.

A representative of the Kansas Health Institute provided an overview of State Innovation (Section 1332) waivers. Section 1332 of the Patient Protection and Affordable Care Act (ACA) allows states to apply to the Secretary of the U.S. Department of Health and Human Services (HHS) for a waiver to develop and implement state-specific approaches and strategies to health reform and coverage to provide citizens with access to affordable health care. States can either use

existing statutory authority to enforce the ACA and issue a regulation or executive order or enact a new state law to apply for and implement a waiver. However, states can simultaneously pursue legislative authority to pursue a waiver while developing and drafting a waiver application and actuarial analysis. Section 1332 waivers, once approved, may remain in effect for five years and can be extended. States that receive waivers may become eligible for federal pass-through funding to help implement waiver plans.

A state's application must demonstrate its proposed waiver plan will:

- Provide comprehensive coverage that is comparable to the coverage offered through the ACA;
- Ensure affordability by providing coverage and cost-sharing protection against excessive out-of-pocket spending;
- Provide coverage to at least a comparable number of residents as the ACA; and
- Ensure the waiver plan will not increase the federal deficit.

Through a waiver, certain provisions of the ACA and the Internal Revenue Code can be waived, such as establishing qualified health plans (QHPs), consumer choices and insurance competition through health insurance, premium tax credits and cost-sharing reductions for QHPs offered within the marketplace, and employer shared responsibility. Other provisions such as pre-existing condition protections, allowable premium rating factors, including age bands; guaranteed availability and renewability of health coverage; risk adjustment; and eligibility determinations under certain premium tax credits, cost sharing reductions, Medicaid, and the Children's Health Insurance Plan (CHIP) cannot be waived.

Concerning federal guidance to states, in March 2017, HHS issued a letter to all governors encouraging them to submit Section 1332 waiver applications to address cost and coverage issues in their individual health insurance markets. HHS

specifically encouraged states to consider implementing a high-risk pool or state-operated reinsurance program to lower marketplace premiums. In October and November 2018, HHS issued new guidance to states designed to give more flexibility in the design of Section 1332 waivers and now refers to them as State Relief and Empowerment waivers. States are encouraged to reach out to HHS for assistance in formulating an approach that meets the requirements of Section 1332. HHS also identified five principals for a high-performing health care system that will be considered when reviewing waiver applications and expressed that states should aim to provide increased access to affordable private market coverage, encourage sustainable spending growth, foster state innovation, support and empower those in need, and promote consumer-driven health care.

States can direct public subsidies into a defined-contribution, consumer-directed account that individuals may use to pay health insurance premiums or other health care expenses. States can create a new, state-administered subsidy program to meet the needs of its population. States could provide financial assistance for different types of health insurance plans, including non-QHPs, to potentially increase consumer choice of more affordable options. To give more flexibility to implement reinsurance or high-risk pool programs, states may waive the single-risk pool requirement.

If a state's waiver is approved and results in savings to the federal government for advance premium tax credits (APTCs) or small business tax credits, the state can receive those savings as pass-through funding and use them to help fund the cost of implementing the state waiver program.

APTCs are refundable tax credits designed to help eligible individuals and families with annual household incomes of at least 100 percent—but no more than 400 percent—of FPL (\$25,100 to \$100,400 for a family of four in 2019) to purchase insurance through health insurance marketplaces created under the ACA. When individuals and families enroll through the marketplace, they can choose to have the marketplace compute the estimated APTC that is paid to the insurance company to lower their monthly premiums. The amount of the APTC is generally equal to the premium for the second-lowest cost silver plan available through the marketplace that applies to

individuals enrolled in the plan, minus a certain percentage of their household income.

Federal regulations also authorize states to submit a single “coordinated waiver application” to the Secretary of HHS for a waiver under Section 1332 and under other existing waiver processes (e.g., Section 1115), which will be evaluated independently according to the applicable federal law.

To date, HHS has approved Section 1332 waivers for 13 states. Of the approved waivers, 12 were to establish state-based reinsurance programs. States that will be implementing reinsurance programs for plan year 2020 include Colorado, Delaware, Montana, North Dakota, and Rhode Island. States with approved waivers projected reductions in premiums ranging from 5.9 percent to 30.0 percent.

Individual Health Insurance Marketplace

The Director of the Health and Life Division (Director), Kansas Insurance Department (KID), provided an overview of the individual health insurance marketplace in Kansas, covering the demographics and statistics of the insured and uninsured. The Director described the several ways persons can apply through the federally facilitated marketplace (FFM). In 2020, consumers shopping on the FFM in Kansas will have the opportunity to choose from 82 individual policies offered by five health insurance companies depending upon where they live. This is an increase of 59 plans over the 2019 number. Concerning categories of insurance plans, catastrophic plans must have actuarial values below 60 percent, meaning the plans will cover less than 60 percent of the expected cost. Bronze plans and expanded bronze plans have actuarial values of at least 60 percent. Silver plans have an actuarial value of at least 70 percent. Gold plans have an actuarial value of at least 80 percent, and platinum plans have an actuarial value of at least 90 percent.

The Director explained the APTCs, which is the tax credit based on the household information and income estimate included in a FFM application. The premium tax credit is only available through the FFM. If income or

household information changes, the premium tax credit will likely change as well. Of the 89,993 individuals who made plan selections as most recently reported, the average premium is \$661, and the average premium after the APTC is \$149. Of the 77,446 individuals receiving the APTC, the average credit received is \$596, and the average premium among consumers after the APTC is \$76.

The Cost Sharing Reduction (CSR), the Director explained, is a discount that lowers what an enrollee pays for their deductibles, coinsurance, and co-payments. The enrollee must purchase a Silver plan to receive the extra savings. Eligibility is determined during completion of a Marketplace application. If the enrollee qualifies for CSR, they also have a lower out-of-pocket maximum. People with incomes between 100 and 150 percent of FPL can enroll in a plan where the actuarial value is increased to 94 percent. People with incomes between 150 and 200 percent FPL can enroll in a plan where the actuarial value is increased to 87 percent. People with incomes between 200 and 250 percent FPL can enroll in a plan where the actuarial value is increased to 73 percent. A fourth variant is a zero cost-sharing plan that is available to certain Native Americans.

Open enrollment for plan year 2020 begins November 1, 2019, and ends December 15, 2019. Kansans may enroll in coverage, stay on their current policy (if available), or enroll in a different policy from the same company or a different company. Consumers currently enrolled in a QHP through the FFM may be eligible for automatic re-enrollment. Anyone wishing to have coverage effective January 1, 2020, must complete the application process by December 15, 2019. After December 15, 2019, the only way to obtain coverage is *via* a special enrollment period due to a qualifying event.

Medicaid Expansion Experience in Other States

A representative of AdventHealth Mid-America Region reviewed Medicaid expansion experience in other states. The conferee reviewed data from Colorado, Illinois, and Kentucky showing the number of people covered by Medicaid or CHIP as of July 2018, the increase in the number of people covered by Medicaid or CHIP from Fall 2013 to July 2018, and the

reduction in the uninsured rate from 2013 to 2017. These three states have accepted federal Medicaid expansion.

Rural Hospitals

Representatives of the University of Kansas Health Systems (UKHS) Care Collaborative provided testimony concerning rural hospitals, which included data on rural quality performance measures, chronic care management, and the impact on total cost of care. Access to health care is defined as having timely use of personal health services to achieve the best possible health outcome. Measuring access is a complex task when trying to include dimensions besides availability of services, such as quality, effectiveness, and efficiency.

Persons in Kansas who need care generally have lower socioeconomic status, higher rates of health risk behaviors, limited access to health care specialists and sub-specialists, and limited job opportunities.

Rural health issues, which started in the 1990s, include an increase in age-adjusted mortality, disability, and chronic diseases. This is due to several causes, including obesity, cancer, heart disease, diabetes, injury-related deaths, and chronic conditions.

Studies demonstrate that insurance coverage impacts health and mortality outcomes, as well as reducing disparities. Providers need to consider “upstream” issues, such as reducing risk factors that lead to illness and chronic conditions and include social determinants of health. The “downstream” consequences of the lack of access can lead to more advanced stages of cancer, renal disease, or diabetes at the time of diagnosis, thus increasing costs and decreasing outcomes.

There are more than 170 rural health clinics, 100 safety net clinics, and 57 federally qualified health centers, that are required to provide care regardless of insurance coverage or ability to pay. Like critical access hospitals, the reimbursement models for some are cost-based. Additional payments are possible based on modeling that includes utilizing sliding-fee scales; certain services required, which are not likely to offset

reduced payments from volume; and rural population characteristics.

A representative of HaysMed discussed how Medicaid expansion would impact rural Kansas. While not the single solution to all the challenges that health care faces today, the representative stated it is one of the short-term solutions to be implemented as longer-term options are developed. More than 130,000 Kansans would benefit.

A representative from the Neosho Memorial Regional Medical Center shared comments concerning what it is like to live in Southeast Kansas where many of the residents work multiple part-time jobs and do not have access to affordable health insurance. The financial margins in rural hospitals in Kansas are thin. Additional funding would allow the Neosho facility to increase staff wages, purchase needed equipment to improve services, and address public health issues.

A representative from the Kansas Hospital Association indicated Kansas has the highest number of at-risk hospitals in the country. There is discussion about the possible creation of another model that will allow some flexibility for these challenged facilities, requiring Congress to change Medicare law. From the Legislature, support would be needed with rules and regulations concerning the definition of what it means to be a hospital. The conferee stated a literature review conducted by the Kaiser Family Foundation indicated Medicaid expansions result in reductions in uncompensated care costs for hospitals and clinics. A growing number of studies show an association between expansion and gains in employment as well as growth in the labor market (with a minority of studies showing neutral effects in this area). Most analyses that looked at rural and urban coverage changes find that Medicaid expansion has had a particularly large impact in rural areas. Research shows that Medicaid expansions result in reductions in uninsured medical visits and uncompensated care costs. Studies demonstrate that Medicaid expansion has significantly improved hospital operating margins and financial performance.

A representative of Navigant, a healthcare consultant firm, suggested a multi-step approach

to assess community health needs, strategic, and operational transformation opportunities in rural health. The factors that contribute to rural hospital success encompass more than just clinical services and reimbursement. Community-specific issues, such as out-migration, workforce availability, and employment, are critical to identifying effective approaches. The conferee shared information concerning the firm's work in Tennessee to assist with its Rural Hospital Transformation Program.

Health Insurance Exchange Experience, Lock-out Period, Social Determinants of Health, and Medicaid Plan Tiers

A representative of Centene provided testimony on state innovation and Medicaid expansion as experienced by that company. Experience in other states suggests the expansion population may have different healthcare needs than traditional Medicaid population (*e.g.*, behavioral health needs) and unique opportunities for support through addressing social determinants of health (SDoH). Research shows enrollees may have complex needs, such as homelessness, mental illness, and substance abuse. Enrollees reported improved health, ability to work, and job seeking after receiving coverage. However, some enrollees faced persistent barriers to employment, such as poor health, disability, caregiving responsibilities, and older age. There is often "pent-up" demand in the first year of expansion with an increase in hospitalizations, which return to comparable rates of utilization as non-expanded states in the second year. There may be an opportunity to increase supply for primary care to improve access. Additionally, federally qualified health centers have greater financial stability in expansion states and could be used to promote access. The four areas of consideration with Medicaid expansion are eligibility, delivery system, program design, and implementation.

Workforce Development System

The Director of Workforce Development, Kansas Department of Commerce, provided an overview of 11 various workforce services available in the state. Under the KANSASWORKS umbrella, businesses, job candidates, and educational institutions are linked to ensure employers can find skilled workers.

Employment services are provided to employers and job candidates through the state's 27 workforce centers, online or virtual services, and the mobile workforce center. The federally funded workforce development programs are delivered, in part, through local workforce centers. These employer-driven services include recruiting skilled workers, screening and assessing job candidates, and identifying individuals needing skill enhancement.

Universal access is granted to all employers and Kansans for labor exchange, labor recruitment, assessment, testing, and screening services. Qualified access to intensive training and related services is provided to eligible Kansans under the guidance and direction of a Local Workforce Development Board (LWDB). Specialized placement and job location assistance is available to targeted populations, such as veterans, those displaced from work because of foreign competition, and migrant and seasonal farm workers.

Status and Stability of Tobacco Tax Collection, Impact of Increase in Tobacco Tax

The Director of Research and Analysis, Kansas Department of Revenue (KDOR), provided testimony concerning the status and stability of tobacco tax collection and the impact of an increase in the tobacco tax. Kansas has three different excise taxes on tobacco or smoking products: cigarettes, other tobacco products, and consumable materials. The tax on cigarettes was enacted in 1927 and was last increased in 2015. As of July 1, 2015, the tax on cigarettes is \$1.29 for a pack of 20 cigarettes and \$1.61 for a pack of 25 cigarettes. The tax on the privilege of selling tobacco products was enacted in 1972 and is 10 percent of the wholesale price of the product. Tobacco products are generally defined as a variety of smoking and chewing tobaccos but exclude cigarettes. The tax on the privilege of selling electronic cigarettes was enacted in 2015 with the tax of \$0.05 per milliliter of consumable material imposed on July 1, 2017. Consumable material is defined to mean any liquid solution or other material that is depleted as an electronic cigarette is used.

KDOR estimated that if the price of a 20-pack of cigarettes increased by \$0.50, \$1.00, or \$1.50,

the additional revenue would be \$31.3 million, \$53.14 million, or \$66.66 million, respectively, in FY 2021. Assuming the tax on a 20-pack of cigarettes stayed at the current \$1.29, and the tax on milliliters (mls) increased to \$0.43/ml, \$0.65/ml, or \$1.29/ml, then the additional revenue from e-cigarettes would be \$7.9 million, \$12.42 million, or \$25.34 million, respectively, in FY 2021. Assuming the tax on a 20-pack of cigarettes increased by \$1.00 to \$2.29, and the ml tax increased to \$0.76/ml, \$1.15/ml, or \$2.29/ml, then the additional revenue from e-cigarettes would be \$14.67 million, \$22.55 million, or \$44.84 million, respectively, in FY 2021. The e-cigarette tax revenue would be estimated to increase in subsequent fiscal years while the revenues on cigarettes would be estimated to decrease.

COMMITTEE RECOMMENDATIONS

The Select Committee proposes bill draft 20rs1873 be revised to clarify the premium charged to covered individuals whose income is greater than 100 percent of the federal poverty level would be equal to 5 percent of modified adjusted gross income assessed on an individual basis, but the aggregate share cannot exceed 5 percent of the modified adjusted gross income of the household, and the revised bill draft reflecting the clarification be provided to the members of the Senate Select Committee on Healthcare Access.

The Select Committee recommends a copy of 20rs1873, as revised, be delivered to the Special Committee on Medicaid Expansion.

The Select Committee requests the Office of Revisor of Statutes to prepare two memorandums to be delivered to the Special Committee on Medicaid Expansion by comparing bill draft 20rs1873, as revised, to:

- 2019 HB 2066, as amended by the House Committee of the Whole, with clarification the 5.0 percent premium charge in the revised bill draft would not address the same group of persons as those who would be assessed the \$25 monthly fee in 2019 HB 2066; and
- 2019 SB 54.

To the extent possible under the law, the Select Committee requests and encourages the Kansas Insurance Department to begin work on a Section 1332 waiver and contract with an actuarial expert on Section 1332 waivers, without requiring approval from the Kansas Department of Administration to enter into a contract for such actuarial services, as timing is of the essence.

If the Select Committee is authorized to continue working on 20rs1873, as revised, it is recommended the bill be introduced on the first day possible and referred to the Senate Select Committee on Healthcare Access, and if the Select Committee is not authorized to continue, then the revised bill draft be introduced on the first day possible and referred to the Senate Committee on Public Health and Welfare.

The Select Committee requests the Kansas Department for Aging and Disability Services provide testimony to the committee that hears 20rs1873, as revised, and apply for a waiver *via* statute on the Institutions for Mental Disease (IMD) exclusion recommended by the Task Force on Mental Health and also use the guidelines CMS published in their November 1, 2017, letter to state Medicaid directors on that subject that integrated crisis stabilization centers into the IMD exclusion.

The Select Committee requests the Kansas Hospital Association (KHA) develop a transparency plan to analyze any current cost shifting to commercial insurance plans and a transparency plan to measure in detail uncompensated care (*e.g.*, charity, bad debt, in-kind donations) on an allowable, not a gross charge, perspective net of disproportionate share hospital (DSH) payments.

The Select Committee requests the Kansas Department of Commerce initiate a rural health care task force, in the vein of the model established in Tennessee, to investigate the health care issues in rural Kansas.

The Select Committee requests KHA work with the University of Kansas Health System to evaluate applying to CMS for a demonstration project for a modified rural health delivery system.

Pending the appropriate approval as per Legislative Leadership Council policy, a letter be sent from the Senate Select Committee on Healthcare Access to the Kansas Congressional delegation asking for their support of the efforts and help in the passage of legislation to improve the fiscal health and modify the delivery system of rural hospitals and providers.

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Minority Report

As members of the Select Senate Committee on Healthcare Access, we are encouraged by the initial discussions about Medicaid expansion going into the 2020 session of the Kansas Legislature. However, we have concerns about many of the provisions in the *20rs1873* bill draft that was recommended by majority party members of the Committee.

We believe a Medicaid expansion bill must be simple and cost effective. The Committee bill is anything but that. It is significantly more complicated, more expensive, and needlessly adds more bureaucratic red tape than the plans offered by Governor Kelly or approved with bipartisan support in the Kansas House of Representatives.

The bill sets up a three-step process for submitting 1115 and 1332 waivers to the Centers for Medicare and Medicaid Services (CMS) for approval. The first two steps have been denied in other states by CMS this year. Specifically, after spending significant time and taxpayer money, both the Utah and Idaho waivers were rejected by CMS. After that rejection, those two states proceeded with full, straightforward Medicaid expansion. Kansas should follow their example.

Submitting waivers that we know CMS will deny creates a delay of implementation of the third step in the Committee bill – allowing for straightforward Medicaid expansion which we know CMS will approve. In addition, we are concerned that the Committee bill does not establish “a time certain” for the submission of a 1115 waiver to CMS.

The Committee bill provides, “*The insurance commissioner shall design the reinsurance program in coordination with the secretary of health and environment to offset any cost of the 1115 waiver...*” (New Sec. 2 (B), page 2). Both the 1115 waiver and 1332 waiver are required to be cost neutral on their own under federal law. We believe CMS will not permit us to co-mingle these waivers.

Reinsurance has nothing to do with Medicaid expansion and should not be included in any bill to expand Medicaid. This idea has never been considered previously by the Legislature in the six years Medicaid expansion has been discussed.

Establishing a reinsurance program is a costly, multi-year process.

In Colorado, for example, a reinsurance program *via* a 1332 waiver was discussed for three years after stakeholder meetings, actuarial analyses and certifications, economic analyses through the Insurance Department, time to draft a waiver and engage with CMS, a public comment period, time to engage their federal delegation, in addition to the 180-day application process itself. It is unrealistic to assume a reinsurance program can be successfully implemented in Kansas in less than a year.

<https://www.colorado.gov/pacific/dora/cms-approves-colorados-1332-waiver-reinsurance-program>

The first step for implementing a reinsurance program should be separate legislation to instruct the Kansas Insurance Department to conduct a feasibility study to determine if reinsurance would be cost effective for the Kansas insurance marketplace.

Establishing a reinsurance program will require a tax increase, which will be very controversial in an election year. We oppose including a tax increase in a Medicaid expansion bill when both the Governor and Kansas House of Representatives have offered proposals to expand Medicaid to 150,000 Kansans **without** a tax increase.

The Committee bill provides, *“The secretary of commerce shall coordinate with secretary of health and environment to certify to the secretary of health and environment each covered individual’s compliance with this section.”* (New Sec. 3a, page 4) Also: *“Such evaluation shall be a prerequisite for coverage under the act.”* (New Sec. 3b, page 5)

While we were led to believe the Committee bill has no work requirement, we believe this provision will create harmful barriers to healthcare access, similarly to an actual work requirement. Instead of simply utilizing the current KANSASWORKS program, it requires a verification process as a condition of eligibility. So, while the beneficiary may not be denied coverage if they cannot find work, the reporting/verification is what created problems in states like Kentucky and Arkansas. The Department of Commerce is very worried about the vague language and what will be required to “track” outcomes.

Another concern we have is the bill adds co-pays for non-urgent care. *“The secretary of health and environment shall submit...waiver or other approval request to assess each covered individual a copayment for each instance of non-urgent emergency care in an amount determined by the secretary of health and environment.”* (New Sec. 4b, page 6)

The burden for collecting copayments falls onto providers. Also, KDHE does not have a definition for “non-urgent emergency care.”

We believe the penalties for nonpayment of premiums are extremely punitive. They are among the highest and harshest in the nation (New Sec. 4c, page 6). Individuals become ineligible when: First coverage premium payment is not made; Delinquent in making payment by 60 days or more; Delinquent by more than 60 days triggers a 6-month lockout. The KDHE Secretary is given no discretion, so this may put sick people in jeopardy of losing their insurance when they need it the most.

Lockouts result in Kansans “flip-flopping” between being insured and not being insured. This has a negative impact on continuity of care and is detrimental to improving access to healthcare and health insurance. This makes it harder for managed care organizations (MCOs) to effectively manage and coordinate care and harder to measure the quality of care beneficiaries receive.

Multiple studies have found that regular and ongoing access to healthcare reduced preventable hospitalizations for individuals with chronic diseases. In addition, lockouts interfere with treatment for people with mental health and substance use disorders, where continuity of care is extremely important.

The Committee bill provides, *“In awarding any contract for an entity to administer state Medicaid services using a managed care delivery system, the secretary of health and environment shall: require that any entity administering state Medicaid services provide tiered benefit plans with enhanced benefits for individuals who demonstrate healthy behaviors as determined by the secretary of health and environment .”* (New Sec. 6b,3, pages 7-8)

Only Indiana and Nebraska have pursued tiered plans. This will be an expensive, complicated undertaking for the agency and especially for providers. It introduces implementation and on-going operational complexity, which results in additional administrative costs. The implementation costs related to system changes would require around 1,300 hours and cost about \$156,000 for the state system. Similar costs will also be incurred by each MCO. This is estimated to be around \$468,000. The ongoing administrative costs for this are unknown.

Tiered benefit plans could also be detrimental to the Medicaid network, as providers would likely begin denying Medicaid patients. There is no way for a provider to track a beneficiary’s plan.

The Committee bill includes a severability clause should the federal match fall below 90%. (New Sec. 7, page 8) It requires that coverage terminates beginning the first day that the FMAP falls below 90%, resulting in immediate loss of coverage. This is more punitive than the House legislation.

Our last concern is that the Committee bill provides, *“The secretary of corrections shall coordinate with county sheriffs to facilitate Medicaid coverage for any inmate incarcerated in a Kansas jail during any time period that the inmate is eligible for coverage.”* (New Sec. 12, page 11) It is unclear whether the Secretary even has jurisdiction to do this.

As evidenced by the experiences of those states who have already expanded Medicaid in a straightforward manner, we conclude that the Legislature, working together with Governor Kelly, should keep the Kansas plan to expand Medicaid simple and cost effective. That means removing the complicated, unnecessary, and proven unsuccessful provisions from the bill draft recommended by the Select Senate Committee on Healthcare Access. We believe doing so is the best way to ensure fiscal responsibility while also providing thousands of Kansans much needed access to affordable healthcare in a timely manner.

Senator Barbara Bollier
Senator Anthony Hensley
Senator Pat Pettey