Approved: February 13, 2004
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairperson Susan Wagle at 1:30 p.m. on February 2, 2004 in Room 231-N of the Capitol.

All members were present except:
Senator David Haley- excused
Mr. Norm Furse, Revisor of Statutes

Committee staff present:
Ms. Emalene Correll, Legislative Research
Mrs. Diana Lee, Revisor of Statutes
Ms. Margaret Cianciarulo, Committee Secretary

Conferees appearing before the committee:
Ms. Karla Finnell, Executive Director, Kansas Association of the Medically Underserved (KAMU)

Others attending:
Please See Attached List.

Introduction of Bills

Upon calling the meeting to order, Chairperson Wagle recognized Mr. Larry Williams, Executive Director, Kansas Dental Board who asked that the Committee introduce legislation concerning dentistry, relating to the administering of sedation and anaesthetics in dental offices. Senator Barnett made a motion to introduce this legislation. It was seconded by Senator Jordan and the motion passed.

The Chair then called on Mr. Larry Buening, Executive Director, Kansas State Board of Healing Arts, who also asked that the Committee introduce legislation concerning institutional licenses under the Kansas healing arts act; amending K.S.A.65-2895 and repealing the existing section. Senator Steineger made a motion to introduce this legislation. It was seconded by Senator Salmans and the motion passed.

Presentation on "Growing Primary Care Clinics and Community Health Centers Within the State"

The Chair then announced to the Committee that they would be hearing a presentation from Ms. Karla Finnell, Executive Director of the Kansas Association of the Medically Underserved (KAMU), who would be presenting information regarding the primary care clinics and community health centers within the State. A copy of her presentation is (Attachment 1) attached hereto and incorporated into the minutes as referenced. Highlights included:

1) Who they were - a diverse group for primary care safety net clinics whose mission is to promote accessible high quality comprehensive primary care services for the medically underserved without regard to ability to pay;

2) Their services (ex. Inform policy makers, technical assistance, placing health professional students as interns in CHC's);

3) The facts (ex. 280,000 residents lack access to health insurance and 72% of uninsured had a family income below 200% of the federal poverty level (FPL));

4) The impact of lack of health insurance (ex. Uninsured have a higher utilization of the emergency room, have not had a doctor visit within the last 6 months, and forego needed care resulting in negative health status and adverse financial consequences);

5) Barriers to accessing care and the role of safety net primary care providers (ex. The number one cause is cost, with others ranging from language, transportation, hours, to availability of providers, whose role it is to fill in this gap); and lastly,

6) Different models of primary care safety net clinics (ex. Community health centers, federally qualified health center-look alike, rural , faith-based and indigent clinics.)

Ms. Finnell then stood for questions which came from Senators Wagle, Barnett, Jordan, and Steineger, and Ms. Correll ranging from do you serve No-Questions-Asked and the undocumented, is there any way a doctor could access the drugs offered (ex. Chemo) or do they need to go through the clinic, do you give chemotherapy drugs, what can we as legislatures do to help grow this safety net, do you ever raise non-profit funds, overlapping, has the behavioral health clinic side been looked at, availability of data on the undocumented using the clinics/hospitals in Wichita to are you seeing any work related injuries or illnesses relating to types of low paying jobs (ex. Roofers making $6.00/hr. working in August)?

Approval of Minutes

The minutes of January 15, 20, 21, and 22, distributed at the January-27-04 Committee meeting were approved on January 30, 2004.

Adjournment

As there was no further business, the meeting was adjourned. The time was 2:25 p.m.

The next meeting is scheduled for Tuesday, February 3, 2004.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: Monday. February 2.2004

NAME	REPRESENTING
Kyle Brewster	Kansas SRS-Medicaid
Angela Harness	intern- Sen Brungardt
Karla Finnell	KAMU
Larry Williamson	Kansas Dental Board
Mike Hammond	Assn. of Cmtys of KS
Shelli Sweeney	"
Lee Walker	
Sarah Kessinger	HNS
LARRY BUENING	BD OF HEALING ARTS
Kevin Brown	Hein Law Firm
Mike Hattles	Ks. Gov't. Consulting

15 in att.

Primary Care Safety Net Clinics -

Growing Primary Care Clinics and Community Health Centers in the State

Increasing *Access to Healthcare for Underserved Populations*

Senate Public Health & Welfare Committee
Attachment: 1
Date: February 2, 2004

Presentation to Public Health and Welfare Committee

February 2, 2004

Karla Finnell, J.D., M.P.H.

Kansas Association for the Medically Underserved

KAMU

Who We Are

Kansas Association for the Medically Underserved

- An Association whose membership is a diverse group of primary care safety net clinics
- Our mission is to promote accessible high quality comprehensive primary care services for the medically underserved without regard to ability to pay.
  - Underserved may face barriers to accessing health care
    - ability to pay, cultural or linguistic barriers, a lack of or insufficient number of health professionals in the community (usually uninsured, Medicaid, persons below 200% of FPL)
- 11 staff positions
- Governed by Board of Directors

Services

- Inform Policy Makers on Safety Net Policy Issues
- Technical Assistance to Safety Net Providers
  - Financial/Management
  - Board Training
  - Clinical Provider Training
- Community Development
- SEARCH
  - Place health professional students in CHCs and other safety net providers as interns
- AmeriCorps
  - Host organization for 20 volunteers who provide outreach, translation, and health education services for clinics
- Health Disparities Colloboratives; Kansas Clinicians Network

Uninsured & Other Undeserved Populations

Access to Healthcare Services

Uninsured in Kansas

- 280,000 residents lack access to health insurance
- 72% of uninsured have family income < 200% of FPL
- Uninsured tend to be chronically uninsured
- Sparse population impacts access to health care
  - 89.5% of 105 counties are classified as rural by the federal government
  - 80% are designated as HPSAs.

* Health Professional Shortage Areas are Federally-Determined Designations based on population and health status factors which make areas eligible for federal resources such as grant funding NHSC clinicians and J-1 Physicians

Impact of Lack of Health Insurance

- Uninsured are less likely to have a usual source of health care (67.4% vs. 87%)
- Uninsured have a higher utilization of the emergency room (17.7% vs. 12.5%)
- Uninsured are less likely to have had a doctor visit within the last six months (29.1% vs. 53.3%).

Impact of Lack of Health Insurance (conti-)

- Uninsured forego needed care, resulting in negative health status and adverse financial consequences.
  - Receive fewer preventive services
  - Less likely to receive regular source of care for chronic conditions
  - Less likely to fill a prescription
  - More likely to be hospitalized for a condition that could have been avoided with access to ambulatory care

Barriers to Accessing Care

- Uninsured adults cite cost as most important reason for not having insurance and obtaining care
  - 45% of uninsured in Kansas stated had trouble paying for a medical bill
  - 40% did not get needed care in the past 12 months because of costs
- Language, Transportation, Hours, Health Literacy
- Availability of Providers
  - Some providers are reluctant to accept public health insurance coverage, such as Medicaid
  - National shortage of dentists, anecdotal evidence suggest problems accessing dental services is more than the ability to pay
  - More difficult to recruit providers in rural areas

Role of the Safety Net Primary Care Providers

- Safety net providers improve access to health care by providing services on a sliding fee scale regardless of ability to pay
- Provide a reliable source of quality health care
- Of the uninsured with a regular source of care in Kansas, 47.2% rely upon safety net clinic

Primary Care Safety Net Clinics

Different Models

Different Models of Primary Care Safety Net Clinics

- Community Health Centers
  - Also known as federally qualified health centers
  - 330 funded clinic
  - Types also include migrant, homeless, public housing and school-based health centers
- Federally Qualified Health Center-Look Alike
- Rural Health Clinics
- Faith-Based Clinics
- Indigent Clinics

Community Health Centers

- Community based non-profit or public primary health care clinics
- Located in an Medically Underserved Area/Population
- Consumer Board Governance Structure
- Provide comprehensive primary health care services including dental and mental health services
- Provide health services to persons in all stages of life cycle
- Provide services on a sliding fee scale to all persons regardless of ability to pay.

Community Health Centers

Required Services

- Primary medical care
- Behavioral health care
- Substance abuse
- Diagnostic lab and X-ray services
- Prenatal and perinatal care
- Cancer and other disease screening
- Eye, ear and dental screening for children
- Well child services
- Immunizations against vaccine-preventable diseases
- Screenings
  - Elevated blood lead levels,
  - communicable diseases
  - cholesterol
- Dental health care
- Family planning services

Community Health Centers

Required Enabling Services

- Case management
- Assistance in obtaining financial support for health and social services
- Referrals to other providers of medical and health-related services including substance abuse and mental health services
- Outreach
- Transportation
- Interpreter services
- Education about health services availability and access

Benefits of Becoming a Community Health Center

- Receive Section 330 funding which provides significant support to improve access to health care services for underserved populations
- Automatically eligible for certification as Medicare and Medicaid FQHC status resulting in cost-based reimbursement for services provided to Medicare and Medicaid patients
- Reimbursement by Medicare of patients 20% deductible ("first dollar" is waived and beneficiary may pay co-payment on a sliding fee scale);
- Eligible to participate in the PHS Section 340B Drug Pricing Program
  - Discounts of 51% on medications from AWP
- Can access free medical malpractice insurance under the Federal Torts Claims Act (FTCA)

Benefits of Becoming a Community Health Center-continued

- Access to Bureau of Primary Care technical assistance
- Access to federal Vaccines for Children Program
- Access to placement of National Health Service Scholars and Loan Repayors
  - Other sites may qualify if agree to accept everyone regardless of ability to pay on a sliding fee scale and accept Medicaid/Medicare

Disadvantages of Becoming A Community Health Center

- Highly competitive, complicated grant process
- Competive grant application every five years
- Annual Financial Status Report (FSR) required
- Comprehensive data reporting annually, (Uniform Data Set, or UDS)
- Comprehensive Primary Care Effectiveness Review (PCER) conducted by the Bureau of Primary Health Care at least every five years. JCAHO accreditation is an alternative.
- Higher level of staffing, both clinical and administrative/management, necessary to meet requirements
- Must accept governance by a community board and direct employee of key professionals, including medical staff

Federally Qualified Look-Alikes

- Meet ALL of the Section 330 program requirements
- Advantages
  - Eligible for certification as Medicare and Medicaid FQHC status, cost-based reimbursement for Medicaid and Medicare Reimbursement by Medicare of deductible ("first dollar" is waived)
  - Eligible to participate in the PHS Section 340B Drug Pricing Program
  - Access to federal Vaccines for Children Program
  - Access to placement of National Health Service Scholars and Loan Repayors
  - No competitive application process
- Disadvantages
  - Do not receive 330 grant support or free malpractice coverage under the Federal Tort Claims Act Coverage
  - Time cycle for application

Rural Health Centers

- Created in 1977 as part Public Law 95-210.
- Intent was to increase availability and accessibility of primary health care services in rural areas
- Eligibility Requirements
  - Privately owned, a non-profit organization or a public entity
  - Staffed at least 50% by a mid-level providers
  - Provide outpatient primary care under supervision of a physician (on site every 2 weeks)
  - Not located in an "Urbanized Areas" as designated by U.S. Census Bureau and Secretary of Health and Human Services
  - Located in a Health Professional Service Area or Medically Underserved Area

Rural Health Clinic

- Other requirements
  - Clean, meet appropriate state and local building standards
  - Minimum of six basic lab tests must be available on site
  - File an annual cost report with the BPHC
  - Maintain adequate medical records for six years

Rural Health Clinic

- Benefits
  - No competitive application process
  - Ownership can be private, public or non-profit
  - Facility can be certified at any time
  - Medicare and Medicaid services receive cost based reimbursement
- Disadvantages
  - No federal grant money for uninsured patients or operational expenses
  - Medicare Patient is responsible for deductible of 20% or "1st dollar" must be paid by patient
  - RHCs are not required to provide care to uninsured or underinsured persons, i.e. regardless of ability to pay

Comparison of RHC and CHC Program

	Rural Health Clinic	Federally Qualified Health Center
Location	Non-Urban MUA or HPSA	MUA or MUP
Organizational Type	For-profit, nonprofit or public entity	Nonprofit or public entity
Governance Requirement	None	Majority user board of directors
Federal 330 Grant funding for operations	None	Yes
Services Provided	Basic primary care	Comprehensive primary health care, mental health, dental health care
Other services required	Basic lab	Pharmacy, lab (as appropriate), enabling services
Mid-level provider required	Yes, 50%	No
Enhanced Medicaid/Medicare	Yes	Yes
Application process	Certification any time	Competitive grant cycles
Access to free medical malpractice coverage (FTCA)	No	Yes
Program Evaluation	Annually	Primary Care Effectiveness Review (PCER) at least every five years or JCAHO accreditation

Faith Based Clinics

- Clinics supported by churches and faith-based foundations, such as the Sisters of Charity, United Methodists Health Ministry Fund.
- Provide primary health care services to medically indigent.
- Benefits-
  - Most likely eligible for free malpractice coverage under the Kansas Tort Claim Act.
  - Eligible entity for local aid to communities grant funds.
  - May be eligible as 330 grantee if otherwise meet eligibility requirements and agree to accept Medicare.
  - Facility has the discretion to determine services and benefits.
  - No public/governmental reporting requirements.
- Disadvantage-
  - Aid to Local Communities funds have been exhausted.
  - No cost based reimbursement under Medicaid.

Indigent Clinics

- Defined as outpatient medical clinic that is a not-for-profit that provides care to the medically indigent. (Kansas)
- Medically indigent are defined as uninsured and Medicaid beneficiaries.
- Benefits-
  - Eligible for malpractice coverage under the Kansas Tort Claim Act.
  - Eligible entity for Aid to Local Communities Grant (KDHE).
- Disadvantage-
  - Aid to Local Communities funds have been exhausted.
  - Not eligible for federal grant money because 330 grantees must accept Medicare in addition to uninsured/Medicaid.
  - No cost based reimbursement under Medicaid.

President Bush's REACH Initiative

Doubling the Capacity of Community Health Centers' Over Five Years

President Bush's REACH Initiative

- 5 year initiative to Double the Capacity of Community Health Centers announced August, 2001
- Goal is to increase funding from $802 million in 2001 to $2 billion by 2006
  - $175 million additional funds in 2002
  - $112 million additional funds in 2003
  - $113 million additional funding in 2004
  - Seeking $250 million additional funds in 2005
- Total program funding is $1.313 billion as of 2004.
- This is the most significant period of growth in the history of the community health center program.

The REACH Initiative-

- Plan to double the capacity of community health centers
  - Funding for 1200 new or expanded access points
  - Over 6 million new patients served by community health centers
  - $650,000 is the maximum funding for new starts, and the amount is continuing each year subject to grant compliance
  - $150,000 may be used the first year to purchase equipment

The REACH Initiative-continued

- Of the 1200 new sites, 670 will be new access points, 530 will be new expansions
- Options for funding
  - New location or a new start
  - Expanded medical capacity
  - New service, behavioral health, dental, pharmacy
- It is anticipated that at least 75% of all new funding will go to existing grantees.

Why Community Health Centers?

- Community Health Centers were started as a federal demonstration project 35 years
- Grown to reflect a board-based constituency of support from federal, state, and local governments as well private philanthropic government
- Nationwide serve 14 million people who would otherwise face barriers to access health care
- Office of Management and Budget cites health center programs as one of the 10 must successful federal programs
- Program recognized by Institute of Medicine for providing high quality care at lower costs and model for reforming the delivery of primary care

Kansas-The Primary Care Safety Net System

A Diverse Mixture of Models by Type and Payor Source

Kansas-Safety Net Clinics

A Diverse Mixture by Type and Funding Sources

There are 34 Federally and State-Funded Safety Net Clinics in Kansas

- 8 Community Health Centers (CHCs)
- 1 Community Health Center with a Healthcare for the Homeless (HCH) Program
- 1 Farmworker Health Voucher Program
- 1 Federally Qualified Look-Alike
- 9 State and Local Funded Clinics w/ No Federal Funding
- 14 Clinics With No State and Federal Funding

Kansas-Safety Net Clinics

- Serving 36 communities in 23 counties
  - 33 sites provide medical care
  - 12 sites provide dental care
  - 5 sites provide mental health care services
  - 3 sites act as referral clinics exclusively
  - More than 90% are located in Rural/Frontier Areas
  - All sites provide access to pharmaceuticals by maintaining a stock of drug samples and assisting patients with manufactures indigent drug program
- Kansas Statewide Farmworker Health Program
  - Statewide voucher program serving 2,449 migrant farm workers. Program is managed by KDHE.

Clients Served

- 122,592 clients served by all primary care safety net providers
  - 95% or more < 200% 0f Poverty
- Patient Mix
  - 64% Uninsured – (1 in 4 of the State's uninsured)
  - 20% Medicaid/Healthwave
  - 4% Medicare
  - 2% Other public
  - 12% Private
- Cost per user overall is $185.00

8 Kansas Based Community Health Centers*

- Serve 41,052 users
- Receive $5.8 million dollars in federal funding; state investment is $400,000.
- Site locations
  - Topeka, Wichita, Emporia, Great Bend, Pittsburgh, Garden City, Liberal, Dodge City, Ulysses, and Junction City
- Comprehensive medical, dental and behavioral health
- Average cost per user is $285.00.

*Excluded support and users to Missouri based health centers with sites located in Kansas City because do not have access to complete financial reports.

Successes in Kansas-

$1.5 M in new revenue to support access to health care

- New Starts
  - We Care Clinic, Inc., Great Bend, KS.
  - Community Health Center of SE Kansas, Pittsburgh
- Medical Expansion Grants
  - Flint Hills Community Health Center, Emporia, KS
- Service Expansion Grants
  - United Methodist Mexican-American Ministries, Inc. (X2), Garden City, KS
  - Flint Hills Community Health Center, Emporia, KS
  - Konza Prairie Community Health Center, Junction City, KS
  - Hunter Health Clinic, Wichita, KS
- 2 Rural Outreach Grants & 5 Community Access Grants
  - Salina and Hays

A Successful 330 Grant Application

The grant process is complicated and competitive.

A Successful Grant Application

- Designation of MUA/MUP
- Needs Assessments-score a 70 or higher
- Grants being funded are rated "exceptional" by Independent Review Committee, scoring 93 of 100 points
- Demonstrating "Readiness", must be operational within 120 days
  - Functional Board with Established By-Laws
  - Business Plan
  - Financial forecast
  - Health Plan
  - Policies and Procedures
  - Location Identified/Building Plan

A Successful Grant Application

"Scope of Services"

- Facility
  - 2-3 exam rooms per provider (100 sq ft.)
  - 2-3 operatories for each team of dentists and hygienists
  - One office for Mental health professional plus group meeting room
  - Conference room
  - Office space
  - Areas for support functions-reception, clinical records, patient waiting and counseling, laboratory and x-ray
- Staffing Pattern
  - Urban-5 FTE medical providers
  - Rural-3 FTE medical providers
  - Support Staff

Strategies for Successful Community Development

Oregon, Oklahoma, Iowa and Nebraska, Texas

Successes of Other States

New Starts/Locations

- Oregon-
  - Increase from 6 sites to 15, 150% increase
- Oklahoma
  - Increase from 6 sites 14 sites, 133% increase
- Nebraska
  - Increase form 7 to 13 sites, 86% increase
- Iowa
  - Increase from 3 to 5 sites, 40% increase
- Kansas
  - Increase from 6 sites to 8 sites, 33% increase

Community Development Successes

- Common Elements of Successful Community Development:
  - Strong Partnerships and Collaborative Roles
  - Developed a plan identifying gaps, prioritizing needs, available resources for development, and strategy for supporting necessary financial resources
  - Looked creatively to provide resources considering local strengths to support growth and development
  - Worked closely with select communities who met initial qualifications and had strong "community" champion

Community Development in Kansas

Strengths and Weaknesses

Unmet Planning Needs in Kansas-

- Vision
  - A system of safety net clinics that provides access to basic primary care services, including dental, that are geographically accessible, affordable, and sustainable
  - Immediate-leverage opportunity for federal resources
  - Long term-Develop a plan to systematically grow safety net in models that are responsive to the need and acceptable to the community

Challenges-Federal Expansion

- Population Distribution-Sparse Populations in Rural Areas and Homogeneous
- Need to demonstrate "sustainability" requires leveraging of state and federal dollars
  - The REACH initiative is based upon a partnership of state, local and federal funding. Guidelines suggest not more than $150.00 per new user.
- Recruitment and Retention-Particularly Dentists and Behavioral Health Professionals
- New Start Must Demonstrate "Readiness"
- Entering the last year of the Growth Initiative

Community Development in Kansas

- Strong Partnerships and Collaborative Roles
  - A Planning Committee has recently been formed to develop strategies to support the growth of the safety net primary care clinics
    - Objectives:
      - Develop a plan identifying gaps and areas of highest need, resources for development, and necessary financial resources
      - Develop tools that will facilitate community needs assessments on local level and other resources
- Work closely with select communities who met initial qualifications and had strong "community" champion
- Provide technical assistance in development of grants and operations starting newly funded site

Strengths and Weaknesses

- Strengths
  - Genuine Interest and Support to Provide Primary Health Care Services to Underserved Population
  - Models of success in Kansas for a number of different types of safety net providers, many of today's CHCS evolved from these different models of safety net providers
  - Many locations meet the designation and needs requirements
  - Can build upon the existing infrastructure of primary care safety net clinics, RHCs and Critical Access Hospitals.
- Weaknesses
  - State General Funds in Kansas Comprise 5% of Average Health Center Budget Compared to 15% Nationally.
  - State Like Clinics is Experiencing Budget Pressures
  - Additional Funds are Needed Operational Support of New and Expanded sites.