Approved: April 1, 2005
Date

MINUTES OF THE SENATE HEALTH CARE STRATEGIES COMMITTEE

The meeting was called to order by Chairman Susan Wagle at 1:30 P.M. on February 10, 2005 in Room 231-N of the Capitol.

Committee members absent:

Committee staff present: Ms. Emalene Correll, Kansas Legislative Research Department
Ms. Terri Weber, Kansas Legislative Research Department
Mr. Jim Wilson, Revisor of Statutes Office
Ms. Margaret Cianciarulo, Committee Secretary

Conferees appearing before the committee: Dr. Gary Daniels, Acting Secretary,
Social and Rehabilitation Services (SRS)
Mr. Jerry Slaughter, Executive Director,
Kansas Medical Society (KMS)
Mr. Tom Bell, President, Kansas Hospital Association
Mr. Patrick Hurley, HealthyKansas Coalition

Hearing on ERO 33 - reorganization of the state's major health care programs

Upon calling the meeting to order, Chairperson Wagle announced there would be a hearing on **ERO 33**, the reorganization of the state's major health care programs into a new business division within the Department of Administration. She then called upon the first proponent conferee, Dr. Gary Daniels, Acting Secretary of Social and Rehabilitation Services (SRS), who stated they are currently identifying the staff who will transfer to the Division of Health Policy and Finance. He also gave a brief illustration of how they expect their relationship with the new entity to work, the transition team's make-up and plan, and how the ERO will allow the future Department of Health Services to concentrate on their person centered mission of protecting children and promoting adult self-sufficiency. A copy of his testimony is (Attachment 1) attached hereto and incorporated into the Minutes as referenced.

The second proponent to testify was Mr. Jerry Slaughter, Executive Director, Kansas Medical Society (KMS), who stated that Medicaid, one of the fastest growing components of the state budget, is essentially a state-administered health insurance program which is housed in a social service agency and if the program were created new today, it is safe to say it would probably not be assigned to the state agency responsible for state-run mental health facilities, community support services for children and adults, and substance abuse programs. A copy of his testimony is (Attachment 2) attached hereto and incorporated into the Minutes as referenced.

Mr. Tom Bell, President, Kansas Hospital Association, was the third proponent conferee who stated their focus is on the movement of the state's medical assistance program to this new office stating that carving Medicaid out of the Department of Social and Rehabilitation Services would allow the state to better focus its communications with the federal government concerning the future of the Medicaid program. A copy of his testimony is (Attachment 3) attached hereto and incorporated into the Minutes as referenced.

The final proponent conferee was Mr. Patrick Hurley, representing the HealthyKansas Coalition, who offered public policy goals, a list of their members and its initiatives, problems the Health Care Cost Containment Commission will address, small businesses given an affordable new private insurance choice allowing them to pool their resources, access to lower-cost prescription drugs, and dedicated health care assessment on tobacco products through the Business Health Policy Committee. A copy of his overview is (Attachment 4) attached hereto and incorporated into the Minutes as approved.

There was no opponent or neutral testimony. Written testimony was offered by Ms. Joy Wheeler, President & CEO of FirstGuard Health Plan. Her company felt this reorganization represents the potential to achieve significant efficiencies and raise the effectiveness and value of the dollars currently spent for health care in our state. A copy of her written testimony is (Attachment 5) attached hereto and incorporated into the Minutes as approved.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

As there was no further testimony, the Chair said that before they proceeded, she wanted to tell the Committee that Senator Barnett and she had spoken to the Senate President and the Majority Leader yesterday about the ERO that sits before this Committee. She stated, when Senator Morris won the presidency, he contacted her and wanted an extensive study on Medicaid to see what the Committee could do to: meet rising costs, make it more efficient, work with our federal delegation on some of the cuts that are coming down from the Bush administration and the reorganization, and with the Governor putting this proposal before the Committee. She stated, they are at a point now where the Committee can accept this ERO and it will go into effect, if the House does not object. She stated, the House Committee on Appropriations did recommend this morning rejecting the ERO, not simply because they oppose the concept but because they want more involvement in drafting the proposal and that this will go before the full House floor. The Chair stated that the Committee has the choice today to bring the ERO up for a vote, to endorse this proposal by doing nothing, or if there are concerns, the Committee can ask for a resolution to reject to be drawn up. At this time, Chairperson Wagle asked for questions.

Questions came from Senators Barnett and Wagle including: were Legislative Research and Kansas Health Institute involved in this process; were they involved in recent times and in the final product, regarding the high cost areas (ex. Long term care) is this a part of your long term proposal to bring that into this area; how can you separate medical needs and social needs (whether it is with Medicaid and long term care or other aspects of Medicaid programs, like children, nutrition, alcohol, etc.); what is the savings of separating these two; are the high cost patients with disabilities included; regarding the comment yesterday about culture, in moving these 125 employees from one building to another are you moving the same culture and how is that going to change in effect, do you envision at some point in time the state developing a policy of best practices and then force that on providers through contract negotiations?

Senator Brungardt stated, like many people he has a lot of questions, but he is willing to extend to those involved that amount of freedom to operate because he feels they do know the subject better than him. Senator Barnett feels this is headed in the right direction, but does have some significant concerns and just hasn't had enough time to digest it. He stated he has faith in Research, but is concerned they were not a part of this and faith in the Kansas Health Institute as well, and beyond Medicaid and data collection, how we analyze data is going to have to be a critical component of what Mr. Day is talking about, evidenced-based medicine needs to be part of this policy as well. Senator Barnett also stated he would have a greater comfort level if this was studied more and if the legislature was part of it because many of the calls he receives are related to Medicaid / SRS and does not want to send something off in another direction without a high level of comfort that he feels is the right thing to do. And lastly, he stated, it may be the exact thing the Committee should do, it may be one idea that needs to be looked at and perhaps adjusted as well. Senator Wagle said she would have to echo Senator Barnett's thoughts. She stated, she likes the concepts but feels as a legislature, with this comprehensive of a change in the way business is done, feels if the Committee works at this together they might be able to come up with a better product than what is before them. She stated, she has leaned after being in the legislature for 14 years, that starting out right in the beginning, makes a better product. Senator Haley commented that he would not play politics with health care and access to it. He stated, he looks to have legislative input and even oversight, but has also learned in his 11 years in the legislature, to listen to the experts who bring in a nonpartisan fashion of compelling arguments and in this instance, to accept this ERO. He stated, "why not, for example, shouldn't we be the largest purchaser of health care if somehow those benefits might somehow trickle down to help the consumer or the patients that are in our state? Since the House has taken action and still has a long way to go to get the support that we need in both chambers that we, here on this Committee, respect the finding of those who have spent so much time and effort working with the Governor to bring this ERO to us, and allow it to go forward."

As there were no further comments or discussions, Chairperson Wagle stated that since the Committee has had the opportunity to look at this more in depth than other members of the Senate, she would like to take a vote on one of the three options: rejecting, accepting, or no recommendation. Senator Schmidt asked for a clarification of "no recommendation" (Does that give us 30-days to gather more information as you suggested and then any one of us can speak to this on the floor and could the Committee go back and visit about Dr. Day's reference to legislative oversight?)

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

Senator Barnett motioned to reject, get the legislature involved, get the people who the Committees is working with today and has referenced, and come up with something very similar but likely better as well. It was seconded by Senator Palmer. The motion passed. (4-3)

Senator Haley and Senator Gilstrap asked that their votes be recorded as no.

Senator Barnett suggested the Committee discuss with leadership taking this to summer study and involving the interested parties, "so we don't lose the effort and this should be one of our priorities in this coming interim." Chairperson Wagle agreed and said they would officially request from Senate leadership the summer study, which was already their intention back in December.

Adjournment

As there was no further business, the meeting was adjourned. The time was 2:30 p.m.

The next meeting is scheduled for February 16, 2005.

SENATE HEALTH CARE STRATEGIES COMMITTEE

GUEST LIST

68 insatt.

DATE: Thursday, February 10, 2005

NAME	REPRESENTING
Larry Magill	Ks Assn of Ins Agents
Robert Day	Gov. office of HP:F
Tanya Dorf	KACIL
Amy Bertrand	DOA
Martha Butler	KSNA - Southwestern College
Jane Schlidran	KSNA - Southwestern College
Ron Seeber	Hein Law Firm
Dan Murray	Federico Consulting
Iva Stamm	self
Larry Pitman	KFMC
Jan Schroeder	KSNA
Mike Reecht	Gaches Braden
Cindy Lash	Post Audit
Sherrie Coke	Self
Virginia Adams	Self
Chuck Hampton	Self
Donna Warner	KSNA DATL
Nelda Jeffery	KSNA DATL
Teresa Sanchez	Baker University School of Nursing

SENATE HEALTH CARE STRATEGIES COMMITTEE

GUEST LIST

DATE: February 10, 2005

NAME	REPRESENTING
[illegible] Burney	DPS
Chad Austin	KHA
Kim Riffel	FHSU
Kyle Kessler	SRS
Shveta Shura	KDHE
Kelly Grenke	KDOA
Bill Brady	KGC
Linda Lubensky	KS Home Care Assoc.
Kinna Meeham	Sen Petersen intern
Sheli Sweeney	Assoc. of Community Mental Health Ctrs.
Josie Torrez	SILCK
Paul Johnson	PACK
Tom Bell	KHA
Jim McLean	KHI
Candy David	SRS
[illegible]	KDHE
Duane Goossen	Dept. of Ad.

Kansas Department of

Social and Rehabilitation Services

Gary Daniels, Acting Secretary

Senate Committee on Health Strategies
February 9, 2005

Effects of ERO 33 on SRS

Dr. Gary Daniels, Acting Secretary
785.296.3271

For additional information contact:
Public and Governmental Services Division
Kyle Kessler, Director of Legislative and Media Affairs

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Senate Health Care Strategies Committee
Date: February 10, 2005
Attachment 1

Kansas Department of Social and Rehabilitation Services
Gary Daniels, Acting Secretary

Senate Committee on Health Strategies
February 9, 2005

Effects of ERO 33 on SRS

Chairperson Wagle and members of the Committee, I am Dr. Gary Daniels, Secretary of Social and Rehabilitation Services. Thank you for the opportunity to appear before you today to present information on how our agency will be affected by ERO 33.

The ERO takes effect on July 1, 2005. On that date, medical services including Medicaid, MediKan, and HealthWave will be transferred from SRS to the Division of Health Policy and Finance within the Department of Administration. The State Employee Health Plan, already located in the Department of Administration, will also move to the Division of Health Policy and Finance. Employees who work in or support the programs that are moving to the Division of Health Policy and Finance will transfer with the program. Likewise, employees who work in or support the programs that remain at SRS will remain at SRS.

We are currently identifying the staff who will transfer to the Division of Health Policy and Finance. Approximately 125 staff who work in or in support of the identified programs will transfer on July 1.

The transition team, made up of staff from the Department of Administration, the Governor's Office, and SRS also is building a detailed plan to ensure a smooth transition and seamless continued operation of these health care programs.

The Department on Aging provides a good illustration of how we expect our relationship with the new entity to work. For example, Aging currently manages Medicaid-funded long-term care services for the elderly through two main programs which are nursing facilities and a Home and Community Based Services (HCBS) waiver. Aging develops its own caseload estimates for nursing facilities which are incorporated into the State's overall consensus caseload estimating process. The state money used to match HCBS and nursing facility services is contained in Aging's budget with the federal dollars to match the state money drawn down by SRS and passed through to Aging. The Medicaid Management Information System (MMIS) currently is overseen by SRS and is used for claims payment and federal reporting of nursing facility and HCBS expenditures. Once Medicaid and the MMIS are transferred to the new Division of Health Policy and Finance, we expect our agency's programs to operate in the same manner.

The Department of SRS will be renamed the Department of Human Services to more accurately reflect its focus on the provision of direct services to Kansans. Services remaining with the Department of Human Services include economic and employment support services, child support enforcement, vocational rehabilitation, child welfare services, mental health services, addiction and prevention services, and community supports and services including the management of the Physical Disability, Developmental Disability, Technology Dependent, and Traumatic Brain Injury Waivers. The new DHS also will manage two state hospitals for persons with physical and developmental disabilities and the three state psychiatric hospitals. The consumers of SRS services and recipients of benefits will realize no change in the way they access or receive these services and benefits.

In conclusion, SRS views this ERO as serving two vital purposes. It will move the Medical Policy Section of SRS to a new business division that can place emphasis and focus on escalating health care costs. This new business division will allow the staff to use its aggregate health care purchasing power for real health care reform. This will better serve many of the consumers our agency helps. Secondly, it will allow the future DHS to concentrate more on our person centered mission of protecting children and promoting adult self-sufficiency as well as sharpening our focus on programs that provide direct services to vulnerable Kansans.

I would be happy to answer any questions from the Committee.

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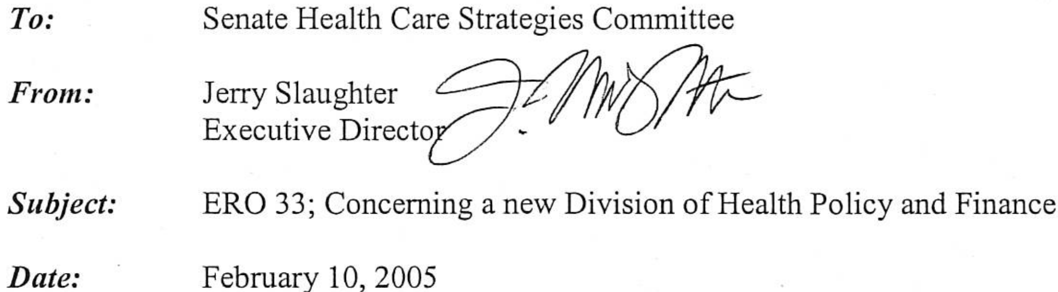
To: Senate Health Care Strategies Committee

From: Jerry Slaughter
Executive Director



Subject: ERO 33; Concerning a new Division of Health Policy and Finance

Date: February 10, 2005

The Kansas Medical Society appreciates the opportunity to appear in support of Executive Reorganization Order 33. The intent of this ERO is to consolidate the state's health care purchasing functions into a single agency, and to thereby improve efficiency, reduce duplication, and enhance the responsiveness of the state as a business partner.

The growth, complexity and cost of health care programs administered by the state has been nothing short of astonishing in recent years. As this committee knows better than others, Medicaid is one of the fastest growing components of the state budget. As it has grown more costly and complex over the past thirty-plus years, however, it has largely remained unchanged in terms of its fundamental culture and administration. Despite its programmatic complexity, Medicaid is essentially a state-administered health insurance program which is housed in a social service agency. If the program were created new today, it is safe to say it would probably not be assigned to the state agency responsible for state-run mental health facilities, community support services for children and adults, and substance abuse programs. It would most likely be housed in an agency that was focused on the arranging for and purchasing of health insurance, either directly or through third party intermediaries.

We view ERO 33 as the first real effort on the part of the state to re-think how it carries out the functions of purchasing health care benefits from physicians, hospitals and other private care providers. We believe it gives the state the opportunity to approach this program with a new perspective, achieve efficiencies, and become a better business partner with the thousands of providers the state relies upon to care for individuals insured by the programs. Most everyone agrees the state simply can't afford to continue doing business as it has in the past, particularly with Medicaid costs increasing at such a rapid pace. We view this reorganization as a positive step in the right direction, one we hope will result in a better program for the population served, for the state, and for the providers who contract with the state to provide care for those individuals.

Senate Health Care Strategies Committee
Date: February 10, 2005
Attachment 2

Thomas L. Bell
President

February 9, 2005

TO: Senate Health Strategies Committee

FROM: Thomas L. Bell, President

RE: **ERO 33**

Thank you for the opportunity to provide comments in support of ERO 33. This ERO would create The Office of Health Planning and Finance within The Department of Administration.

Our focus with regard to this discussion is the movement of the state's medical assistance program to this new office. We see this move as having the potential to reduce the bureaucracy within the Medicaid program. Right now, Medicaid is one layer in the Department of Social and Rehabilitation Services. The ERO would allow more focus on the Medicaid program specifically. Our hope is that such extra focus would allow the program to function more efficiently.

Earlier this week, the President announced his budget proposal in which he proposed numerous changes to the Medicaid program. Whether or not you agree with the President's recommendations, there is no question that the Medicaid program is facing numerous changes in the way it operates. There is also no question that as these changes are debated in the coming years, there will continue to be tension between the state and federal government about what is the appropriate funding share for each level of government. Carving Medicaid out of the Department of Social and Rehabilitation Services will allow the state to better focus its communications with the federal government concerning the future of the Medicaid program.

Thank you for your consideration of our comments.

Senate Health Care Strategies Committee
Date: February 10, 2005
Attachment 3

Kansas Hospital Association
215 SE 8th Ave. • P.O. Box 2308 • Topeka, KS • 66601 • 785/233-7436 • Fax: 785/233-6955 • www.kha-net.org

Testimony
of
Patrick J. Hurley
on behalf of
HealthyKansas Coalition

Presented to the
Senate Healthcare Strategies
Committee
Room 231-N

February 10, 2005

Senate Health Care Strategies Committee
Date: February 10, 2005
Attachment 4

HEALTHYKANSAS COALITION

We the undersigned do hereby join the ***HealthyKansas Coalition*** and express our support for the elements of the HealthyKansas proposal announced by Governor Sebelius and Insurance Commissioner Praeger, which includes the following public policy goals:

1. Contain health care costs by streamlining the health care system through the work of the Health Care Cost Containment Commission and consolidating the state's health care purchasing in the Kansas Health Care Authority;

2. Provide small businesses with an affordable health insurance option to enable them to insure their employees by pooling resources through the Business Health Policy Committee;

3. Provide health care coverage and preventive care to uninsured Kansas children by enrolling them in HealthWave, through a process known as presumptive eligibility;

4. Establish and fund a Pilot Project to provide health care coverage to children of state employees who are income-eligible for HealthWave;

5. Provide Health Insurance Coverage for lower income working parents by increasing the HealthWave eligibility limit to 100% of the Federal Poverty Level;

6. Provide access to lower cost prescription drugs, name brand and generic, for seniors and low-wage working Kansans, including access to the 1-SAVE Rx Program;

7. Establish programs to help Kansans get and stay healthy in business, education, and community settings by increasing physical activity, avoiding tobacco use, healthier diets, and preventive care; and

8. Establish a health care assessment on cigarettes and other tobacco products for the purpose of funding these health care initiatives.

HealthyKansas Coalition Members

AARP
American Cancer Society
American Heart Association
American Lung Association of Kansas
Barber County Community Health Department
Barton County Health Department
Butler County Health Department
C.D.I. Head Start
Central Plains Area Agency on Aging
Clay County Health Department
Coffey County Health Department
Community Health Center of Southeast Kansas
DCCCA, Inc.
Depression & Bipolar Support Alliance
Dickinson County Health Department
Domestic Violence Association of Central Kansas
Douglas County AIDS Project
East Central Kansas Area Agency on Aging
Family Resource Center, Inc.
First Guard Health Plan
Flint Hills Community Health Center

Franklin County Health Department
Harvey County Health Department
Hays Head Start
Heartland Programs
Inter-Faith Ministries, Kansas Benefit Bank
Jayhawk Area Agency on Aging
Junction City-Geary County Health Department
Jefferson County Health Department
Kansas Children's Service League
Kansas Academy of Family Physicians
Kansas Action for Children
Kansas Advocates for Better Care
Kansas AFL-CIO
Kansas Area Agencies on Aging Association
Kansas Association for the Medically Underserved
Kansas Association of Community Action Programs
Kansas Association of Homes & Services for the Aging
Kansas Association of Local Health Departments
Kansas Asthma Coalition
Kansas Center for Assisted Living
Kansas Chapter, American Academy of Pediatrics
Kansas Chapter, National Association of Social Workers
Kansas Children's Service League
Kansas Dental Association
Kansas Dental Hygienists Association
Kansas Family Partnership
Kansas Foundation for Medical Care
Kansas Head Start Association
Kansas Health Care Association
Kansas Health Care Consumer Coalition
Kansas Health Care for All
Kansas Home Care Association
Kansas Hospital Association
Kansas Immunization Action Coalition
Kansas LIFE Project Foundation
Kansas Medical Society
Kansas Podiatric Medical Association
Kansas Psychological Association
Kansas Public Health Association
Kansas Respiratory Care Society
Lawrence-Douglas County Health Department
League of Women Voters of Salina
Lighthouse Hospice, Inc.
March of Dimes Greater Kansas Chapter
Marshall County Health Department
Midland Hospice Care
Morton County Health Department
Nemaha County Home Health & Hospice
Ness County Health Department
NKESC Head Start
North Central/Flint Hills Area Agency on Aging
Northeast Kansas Area Agency on Aging
Northwest Kansas Area Agency on Aging
Northwest Kansas Education Service Center, Head Start
Opportunity Preschool Inc. (Head Start & Early Head Start)
Oral Health Kansas
Pawnee County Health Department
Project EAGLE Community Programs
Rawlins County Health Department
Regional Prevention Central of East Central Kansas
Salina Health Education Foundation
Salina-Saline County Health Department
Smart Start of Northwest Kansas
South Central Kansas Area Agency on Aging
Southeast Kansas—Multi-County Health Department
Southwest Kansas Area Agency on Aging
Stanton County Health Department
State Employees Association of Kansas
The Mental Health Consortium, Inc.
Tobacco Free Coalition of Kansas
Tobacco Free Wichita
Unified Government Public Health Department
United Methodist Church of Kansas
Wyandotte/Leavenworth Area Agency on Aging

HealthyKANSAS

1. Contain costs by streamlining the health care system

Approximately 30 percent of the $12 billion that Kansans spend on health care every year goes to pay for administrative overhead, such as paperwork, claims processing, and provider credentialing. To address the problem, a Health Care Cost Containment Commission will be established to work with doctors, hospitals, and health plans to streamline the health care system. In addition, virtually all of the state's health care purchasing will be combined in a new business division – the Kansas Health Care Authority – to allow the state to use its $1.6 billion in purchasing power to push for real cost-saving reforms.

Cost: None

2. Give small businesses an affordable health insurance option

Two-thirds of working Kansans who cannot afford health insurance are employed by small businesses. Though surveys indicate that many business owners would like to offer health coverage to their employees, most cannot afford it. Through the Business Health Policy Committee, which was created by the Legislature, small businesses that until now have not been able to offer coverage will be given an affordable new private insurance choice that will allow them to pool their resources.

Cost: $12 million

3. Provide coverage and preventative care to Kansas children

Kansans support the goal of providing health care coverage to all Kansas children. As a first step toward that goal, the HealthyKansas initiative will launch an aggressive campaign to enroll the more than 40,000 Kansas children who are eligible for HealthWave coverage but not receiving services. Through a process known as presumptive eligibility, a majority of these children will finally be enrolled. Providing coverage to these eligible children is not only the right thing to do, it will help lower health care costs. Often, children without coverage do not receive preventative care, which forces parents to seek expensive emergency room care when their children become ill.

Cost: $9.5 million

4. Establish pilot project for children of low-income state employees

The 2001 Kansas Legislature authorized, but never funded, a pilot project to provide health coverage to children of state employees with household incomes that qualified them for HealthWave but who federal rules prohibited from receiving the benefit. The HealthyKansas initiative will assist those state employees in obtaining coverage for their children.

Cost: $2.5 million

5. Provide coverage to low-wage, working parents

There are thousands of Kansas parents who work hard and play by the rules but who cannot afford health coverage. Currently, parents who make less than 37 percent of the federal poverty level (FPL) – approximately $7,000 annually for a family of four – are eligible for HealthWave coverage. The HealthyKansas initiative would set that eligibility limit at 100 percent FPL, which for a family of four is $18,850. Providing coverage to more than 30,000 low-wage working parents will significantly reduce the amount of uncompensated care that doctors and hospitals are forced to provide to uninsured Kansans, which in turn will lower everyone's health care costs.

Cost: $25 million

6. Provide access to lower-cost prescription drugs

To help Kansans save money on life-saving prescription drugs, the state will collaborate with Kansas pharmacies to provide low-cost, generic drugs to low-wage working Kansans. The state has also established a Web-based prescription drug resource center to assist Kansas seniors and the uninsured in accessing free and reduced price medications, including access to the I-Save Rx Program to purchase lower cost medication through Europe and Canada.

Cost: $500,000

7. Help Kansans get and stay healthy

No health care reform effort can be successful in containing costs if it does not address the growing epidemic of childhood and adult obesity and the documented health consequences of tobacco use. The Kansas Department of Health and Environment will work with business, education, and community leaders to implement an effective statewide program to help Kansans assume greater personal responsibility for their health and wellness. The program will provide Kansans with incentives to increase their physical activity, avoid tobacco use, follow healthy diets, and seek preventive care.

Cost: None

8. Dedicated health care assessment on tobacco products

A 50 cent per pack health care assessment on cigarettes and a 5 percent health care assessment on other tobacco products, from the current 10 to 15 percent, will be dedicated to funding the HealthyKansas initiative. In Kansas, health care costs related to smoking total more than $724 million annually. A health care assessment on tobacco products will not only raise the needed revenue for HealthyKansas, but is also proven to be the best method of reducing smoking among both youth and adults. Studies show that every 10 percent increase in the price of cigarettes reduces youth smoking by 7 percent and overall cigarette consumption by 3 to 5 percent.

REORGANIZING STATE HEALTH AGENCIES TO MEET CHANGING NEEDS

State Restructuring Efforts In 2003

Since 1908, the nation's governors have worked together through the National Governors Association (NGA) to deal collectively with issues of public policy and governance. The association's mission is to support the work of the governors by providing a nonpartisan forum to help shape and implement national policy, to implement domestic programs, and to solve state problems.

The NGA Center for Best Practices (NGA Center) is a nonprofit, nonpartisan organization that helps Governors and their policy advisors develop and implement innovative solutions to the policy challenges facing them in their states. The NGA Center tracks, evaluates, and disseminates information on state innovations and best practices on a variety of public policy issues.

The NGA Center is a nonprofit, tax-exempt 501(c)(3) corporation with its own board of directors. The work of the NGA Center is primarily funded through foundation grants, federal contracts and cooperative agreements, and a small endowment. As a 501(c)(3) corporation, the NGA Center does not participate in any lobbying activities.

National Governors Association
Center for Best Practices
Hall of States, Suite 267
444 North Capitol Street, N.W.
Washington, DC 20001-1512
(202) 624-5300
fax: (202) 624-5313
www.nga.org/center

EXECUTIVE SUMMARY

In 2003, most states began the year struggling to protect even their highest priority programs from budget reductions. The downturn in state tax revenue collections compounded by the rising cost of the Medicaid program and of health care in general forced states to cut $11.8 billion from their fiscal 2003 enacted budgets. These cuts represented the second largest budget shortfall after fiscal 2002, when 38 states cut their budgets by nearly $13.7 billion. The shortfalls in 2003 were severe enough to affect even priority programs traditionally spared budget cuts, such as K-12 education, higher education, public safety, and aid to towns and cities.[1]

As a result of fiscal pressures, almost every state sought to generate cost savings by allocating public resources more effectively. Because of the prominence of health care costs in most state budgets, health care was placed at the forefront of state cost-containment efforts. Moreover, many governors placed an emphasis on downsizing, reorganizing, and streamlining state government in order to achieve efficiencies and create cost-savings.[2]

This report provides a nationwide snapshot of state health agency organizational structures and examines state efforts to restructure these agencies during 2003. It also describes the focus, goals and overall outcomes of restructuring efforts. Because of Medicaid's prominence in state budgets, it places special emphasis on changes affecting the Medicaid program and its placement in state organizational structures. It also highlights the organizational placement of the State Children's Health Insurance Program (SCHIP) and the Title V Maternal and Child Health Services Block Grant (Title V MCH) program.

This report examines the broad spectrum of restructuring efforts during 2003. It is a snap-shot in time, exploring examples that arose between January and July of 2003, with some follow-up discussion in the fall of that year. NGA looks forward to the opportunity in the near future to go more in depth with some of the critical areas of reorganization, as well as outcomes from these efforts.

State Health Agency Restructuring Trends

During 2003, almost half of the states (22) considered, planned, or implemented structural changes to their state health agency. At least eight of these initiatives were part of broader statewide efforts to transform state government. The Medicaid program was a key component of restructuring efforts in over half of the 22 states—and yet, the Medicaid program was not the only driver of organizational change or state cost-containment efforts. Restructuring states sought to streamline programs and services, improve resource allocation, create cost-savings, enhance managerial oversight of programs, and improve the quality of services.

The 22 states that considered planned, or implemented state health agency restructuring initiatives in 2003 varied considerably in the roles and responsibilities they assigned to their state health agency, as well as in where they placed the agency within the executive branch. Over half of the restructuring states made *intra-agency* changes that affected departments and systems within the agency (e.g., consolidation or elimination of some components of an agency). Eight states implemented *interagency* changes among

[1] National Association of State Budget Officers (NASBO) and National Governors Association (NGA), *Fiscal Survey of the States* (Washington, DC: December 2003). Available at http://www.nasbo.org/publications.php.

[2] T. Nodine, *Governors' State-of-the-State Addresses for 2003: A Summary of Prevalent Themes* (Washington, DC: National Governors Association. 2003).

agencies separate and independent of one another (e.g., the consolidation of five departments into one). Among the 22 states with state health agency restructuring initiatives in 2003, several trends emerged:

- **Clustering health and related human services programs.** At least 18 states considered clustering, collapsing, or otherwise consolidating their health-related activities into one or a smaller number of organizational entities. Several of these initiatives involved organizational change affecting multiple health programs (e.g., Medicaid, SCHIP, and the Title V MCH program).

- **Continuing shifts towards health and human services umbrella structures.** Since 1996, there has been a trend towards using an umbrella agency model to house all or most state health and human services programs. Entering 2003, 21 states reported that their health agency was a component of an umbrella structure, compared with 16 states in 1996. During 2003, no states dismantled umbrella structures where they already existed; in fact, several states considered forming *new* umbrella structures to house their health and human services programs.

- **Consolidating health-related functions.** Nearly all of the 22 restructuring states sought to consolidate their health programs around the core services they provide, functions they perform, and/or special populations they serve. Most abandoned structures that were organized categorically (i.e., a single program providing a core set of services). In fact, several states characterized their restructuring initiatives as an effort to move away from programmatic "silos"—i.e., programs that operate independently even though they may serve the same populations.

- **Centralizing program support functions.** Many state health agency restructuring initiatives involved consolidating various administrative systems and managerial functions (e.g., communications, human resources, legal services, budget and financing, and information technology functions). In many cases, states also sought to overhaul antiquated data systems, particularly as part of efforts to streamline eligibility and enrollment processes for Medicaid and other public programs.

- **Restructuring involving gubernatorial and legislative authority.** The impetus and authority for restructuring varied considerably from state to state, along with the mechanisms used for planning and implementation. To varying degrees, nearly all of the 22 restructuring initiatives involved gubernatorial and/or legislative approval. Only a few initiatives were authorized by the state's health secretary or commissioner alone, and those few were usually contained within divisions or branches of the state health agency. The most common mechanism used to plan and implement a health agency restructuring initiative was a state health agency work group or task force. Often such work groups were made up of members both internal and external to the health agency and were led by the secretary or commissioner of health. Governors in several states established an Office of Health Policy and Planning within the immediate office of the governor to advise their ongoing health care reform efforts.

Effects on Medicaid, SCHIP, and the Title V MCH Program

Although state Medicaid spending growth appeared to be slowing,[3] it remained a significant issue for states and a significant focus of state health agency restructuring initiatives in 2003. In 15 of the 22 states with health agency restructuring initiatives, the initiatives impacted the state Medicaid program. Several initiatives also affected SCHIP and state Title V MCH programs. Where Medicaid was affected, states implemented structural changes to contain Medicaid costs, maximize organizational efficiencies, leverage federal matching funds, and improve data collection. Many of the changes affecting Medicaid were also tied to broader plans for reforming the health care system as a whole. Among the changes were the following:

- **Elevating Medicaid within the state health agency or executive branch.** Because of the Medicaid program's size and scope, four states planned to elevate Medicaid in the executive branch of state government, and one state planned to elevate Medicaid within its existing state health agency structure. A few states even considered elevating Medicaid to report directly to the governor. (The Medicaid authority already reports directly to the governor's office in at least two states nationwide.)

- **Reorganizing SCHIP together with the Medicaid program.** Among the restructuring states with separate SCHIP programs, there were no states that sought to restructure SCHIP to the exclusion of Medicaid. In fact, organizational changes affecting Medicaid and SCHIP were often tied to broader plans for reforming the health care system as a whole.

- **Consolidating Title V MCH programs into a single entity focused on family health.** Title V MCH programs were affected in 13 of the 22 states with health agency restructuring initiatives. In many cases states were centralizing Title V MCH programs with other programs serving similar populations. At least 31 of the 50 states now organize their Title V MCH programs together with other child and family-related programs—e.g., the Special Supplemental Food and Nutrition Program for Women, Infants and Children (WIC), family planning, immunizations—into a division or organizational unit of family health.

Restructuring Challenges and Opportunities

Some of the most significant challenges facing restructuring states involved staffing changes and the complexities associated with merging divergent program philosophies and federal funding streams. Several states reported that challenges occurred most often during the implementation and transition phases of organizational change. However, proper planning and effective communication helped to minimize many of these challenges.

The top challenges identified by restructuring states during 2003 included the following:

- merging divergent service delivery models and philosophies into a common vision and system;
- overcoming internal and external resistance to change;
- maintaining staff morale during staffing changes and program relocation;
- ensuring smooth day-to-day operations and seamless service delivery;

[3] V. Smith, R. Ramesh, K. Gifford, and E. Ellis (Health Management Associates) and Victoria Wachino (Kaiser Commission on Medicaid and the Uninsured), States *Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004—Results from a 50 State Survey.* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, September 2003).

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- addressing the complex legal questions that arise when merging public funding streams; and
- creating an integrated data system and coordinating a smooth transfer of electronic information.

Many states noted that restructuring their health agency along with broader efforts to transform state government provided an opportunity to improve the quality and efficiency of services. Officials in such states are hoping that restructuring initiatives will reduce costs, result in a better use of limited resources, and maximize existing funding streams.

February 9, 2005

To: Senator Susan Wagle, Chair
Senate Committee on Health Care Strategies

From: Joy Wheeler, President & CEO

Subject: ER033

FirstGuard Health Plan supports Executive Reorganization Order 33 which creates a new Division of Health Policy and Finance within the Department of Administration. This ERO consolidates important state medical assistance programs to allow a more business-like approach to the purchasing and delivery of health care services.

FirstGuard is the provider of HealthWave services to over 94,000 Kansans. Over the past six years we have observed first hand the many challenges and complexities involved in delivering medical services to underserved and needy populations throughout our state. We believe this reorganization represents the potential to achieve significant efficiencies and raise the effectiveness and value of the dollars currently spent for health care in our state.

We look forward to continuing our work with the state. This reorganization will provide the opportunity to strengthen our business partnership, ultimately benefiting those health care providers who serve the members we serve.

Thank you for receiving our comments.

Senate Health Care Strategies Committee
Date: February 10, 2005
Attachment 5