Approved: 01/30/08
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman James Barnett at 1:30 P.M. on January 23, 2008 in Room 136-N of the Capitol.

All members were present.

Committee staff present:
Emalene Correll, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Sara Zafar, Kansas Legislative Research Department
Nobuko Folmsbee, Revisor of Statutes
Renae Jefferies, Revisor of Statutes
Jan Lunn, Committee Secretary

Conferees appearing before the committee:
Cathy Harding, Executive Director, Kansas Association for the Medically Underserved
Barbara Gibson, Director, State Primary Care Office, Kansas Department of Health and Environment

Others attending:
In addition to the attached list there were approximately sixteen (16) other attending.

Chairman Barnett called the meeting to order.

Chairman Barnett directed the committee members' attention to follow-up information provided by staff from Legislative Research Services related to current Kansas Health Insurance Mandates and a copy of the Kansas Legislator Briefing Book 2008 "M-2 Kansas Health Insurance Mandates." The attachments (Attachment 1 and Attachment 2) are included and therefore, incorporated into these minutes.

Chairman Barnett indicated approval of the minutes would occur at the end of the meeting.

Information Briefing and Overview of Safety Net Clinics

Chairman Barnett introduced Cathy Harding, Executive Director, Kansas Association for the Medically Underserved (KAMC), who provided very detailed testimony regarding primary safety net clinics in Kansas. Ms. Harding explained these are statewide clinics comprising 33 organizational and 4 associate members who provide health services to low income individuals regardless of ability to pay. She described not only the role these clinics play in the health care system today, but she explained the potential for these clinics in overall health care reform. Ms. Harding discussed the proposed four-component infrastructure development plan and the funding required for it. In addition, discussion was heard related to the importance of enrolling eligible individuals so that these Kansans can find a "medical home" thereby enabling uninsured citizens to improve access to health services and to reduce health care costs. Ms. Harding distributed an attachment of her testimony which is considered to be incorporated into these minutes as a matter of record. (Attachment 3)

Ms. Barbara Gibson, Director, State Primary Care Office, Kansas Department of Health and Environment, was introduced by Chairman Barnett. Ms. Gibson provided information about the state's primary health care safety net and reported on performance of the state-supported clinics and health centers. She indicated that census estimates the current uninsured rate at 302,304 Kansans. Ms. Gibson discussed the struggles to recruit health professionals to provide additional medical and dental services; reported on KDHE's involvement in application for state or federal loan repayment assistance for National Health Service Corps scholars; referenced the Primary Care Clinic Grant Application guidelines and the state application process; and the Conrad/State 30 Program which is another recruitment resource. Ms. Gibson discussed the current funding request for $150,000 for the loan repayment assistance program. (Attachment 4)

Chairman Barnett questioned whether KDHE, KHPA and KAMU are working collaboratively within systems to ensure maximum effectiveness among all agencies. Ms. Gibson responded that relationships are being built and fostered, however, the major issue appears to be work force data sharing with KHPA. Ms. Harding also responded relative to KAMU's work with KHPA regarding participation of outstation eligibility workers

to identify and to enroll eligible Kansans in available programs under KAMU oversight. Chairman Barnett encouraged continued conversation among involved agencies to ensure this critical component is achieved.

Senator Haley moved to accept the minutes of January 16, 2008 and January 17, 2008; Senator Schmidt seconded the motion. The motion carried.

The meeting was adjourned at 2:25pm.

The next meeting is scheduled for Thursday, January 24, 2008.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE GUEST LIST

DATE: January 23, 2008

NAME	REPRESENTING
1-23-08 GUEST LIST	
Gabrielle Huckaby	for Senator Pyle
Barbara Gisson	KDHE
Chris Tilden	KDHE
Michael Hooper	Kearney & Assoc.
Tara Hacker	KHPA
Jennie Roe	KCSL
Dan Morin	KS Medical Society
Tom Wellman	KAMU
Cathy Harding	KAMU
ANN GUSTAFSON	GSK
Mary Jayne Wellbaum	TPKC
Brianna Landon	Sen. Journey
Mike Hutfless	KAMU
Teresa Schwab	OHC
KEVIN ROBERTSON	KS DENTAL ASSN
Michelle Peterson	Capitol Strategies

Current Kansas Health Insurance Mandates

Provider Mandates	Year		Benefit Mandates	Year
Optometrists	1973		Newborn and Adopted Children	1974
Dentists	1973		Alcoholism	1977
Chiropractors	1973		Drug Abuse	1977
Podiatrists	1973		Nervous and Mental Conditions	1977
Psychologists	1974		Mammograms and Pap Smears	1988
Social Workers	1982		Immunizations	1995
Advanced Registered Nurse Practitioners	1990		Maternity Stays	1996
Pharmacists	1994		Prostate Screening	1998
			Diabetes Supplies and Education	1998
			Reconstructive Breast Surgery	1998
			Dental Care in a Medical Facility	1999
			Off-Label Use of Prescription Drugs	1999
			Osteoporosis Diagnosis, Treatment, and Management	2001
			Mental Health Parity for Certain Brain Conditions	2001

Proposed Mandates (2007 - 2008 Session)

Provider Mandates	Bill		Benefit Mandates	Bill
Certain BSRB licensees (clinical prof.counselors, marriage and family therapists, clinical psychotherapists)	HB 2505 HB 2601		Ambulance Services	SB 299
Psychologist/ Social Workers (related to above bills)	HB 2313			
			Assignment of Benefits	SB 175
			Autism Treatment	SB 398
			Colon Cancer Screenings	SB 218
			Dependent Age, Increase	SB 117 SB 243
			Hearing Aids	HB 2125
			Infertility	HB 2413
			Mental Health	SB 380 HB 2351
			Telemedicine	HB 2065

Prepared by M. Calderwood
Kansas Legislative Research Department
01/16/2008

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Financial Institutions and Insurance

M-2 Kansas Health Insurance Mandates

Background

Since 1973, the Kansas Legislature has added new statutes to insurance law that mandate that certain health care providers be paid for services rendered (*provider mandates*) and pay for certain prescribed types of coverage or benefit (*benefit mandates*). In more recent years, laws have been enacted to guarantee a right or protection be extended to the patient (*patient protection mandates*). A table outlining Kansas mandates is included in a later discussion of provider and benefit mandates.

Provider Mandates. The first mandates enacted in Kansas were on behalf of health care providers. In 1973, optometrists, dentists, chiropractors, and podiatrists sought and secured legislation directing insurers to pay for services the providers performed if those services would have been paid for by an insurance company if they had been performed by a practitioner of the healing arts (medical doctors and doctors of osteopathy). In 1974, psychologists sought and received approval of reimbursement for their services on the same basis. In that same year, the Legislature extended the scope of mandated coverages to all policies renewed or issued in Kansas by or for an individual who resides in or is employed in this state (extraterritoriality). Licensed special social workers obtained a mandate in 1982. Advanced nurse practitioners received recognition for reimbursement for services in 1990. In a 1994 mandate, pharmacists gained inclusion in the emerging pharmacy network approach to providing pharmacy services to insured persons.

Benefit Mandates. The first benefit mandate was passed by the 1974 Legislature, through enactment of a bill to require coverage for newborn children. The newborn coverage mandate has been amended to include adopted children and immunizations, as well as a mandatory offer of coverage for the expenses of a birth mother in an adoption. The Legislature began its first review into coverage for alcoholism, drug abuse, and nervous and mental conditions in 1977. The law enacted that year required insurers to make an affirmative offer of such coverage which could be rejected only in writing. This mandate also has been broadened over time, first by becoming a mandated benefit and then as a benefit with minimum dollar amounts of coverage specified by law.

In 1988, mammograms and pap smears were mandated as cancer patients and various cancer interest groups requested mandatory coverage by health insurers. In 1998, male cancer patients and the cancer interest groups sought and received similar mandated coverage for prostate cancer screening. After a number of attempts over the course of more than a decade, supporters of coverage for diabetes were successful in securing mandatory coverage for certain equipment used in the treatment of the disease, as well as for educational costs associated with self-management training.

Table A - Provider and Benefit Mandates

Provider Mandates	Year	Benefit Mandates	Year
Optometrists	1973	Newborn and Adopted Children	1974
Dentists	1973	Alcoholism	1977
Chiropractors	1973	Drug Abuse	1977
Podiatrists	1973	Nervous and Mental Conditions	1977
Psychologists	1974	Mammograms and Pap Smears	1988
Social Workers	1982	Immunizations	1995
Advanced Registered Nurse Practitioners	1990	Maternity Stays	1996
Pharmacists	1994	Prostate Screening	1998
		Diabetes Supplies and Education	1998
		Reconstructive Breast Surgery	1999
		Dental Care in a Medical Facility	1999
		Off-Label Use of Prescription Drugs*	1999
		Osteoporosis Diagnosis, Treatment, and Management	2001
		Mental Health Parity for Certain Brain Conditions	2001

*Off-label use of prescription drugs is limited by allowing for use of a prescription drug (used in cancer treatment) that has not been approved by the federal Food and Drug Administration for that covered indication if the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

Legislative Review

Kansas law (KSA 40-2249a) requires the Legislature to review all state mandated health insurance coverage periodically. The Legislature typically reviews the mandates as amendments rather than reviewing all of the mandates at one time. The provider mandates have been in place, for the most part, longer than the benefit mandates and typically have not been the focus of legislative review. The mandate that has received a great deal of review is the alcohol, drug abuse, and mental illness mandate. A number of interim studies have been conducted on modifying the mandate, with the latest change allowing for mental health parity for certain brain diseases. The Legislature has considered a number of proposed mandates and enacted law to address some of the proposed modifications.

KSA 40-2248 requires the person or organization seeking a mandated coverage for specific health services, specific diseases, or certain providers of health care services as part of individual, group, or

blanket health insurance policies, to submit to the legislative committees that would be assigned to review the proposal an impact report that assesses both the social and financial effects of the proposed mandated coverage. The law also requires the Insurance Commissioner to cooperate with, assist, and provide information to any person or organization required to submit an impact report. The social and financial impacts to be addressed in the impact report are outlined in KSA 40-2249. Social impact factors include:

- The extent to which the treatment or service generally is utilized by a significant portion of the population;
- The extent to which such insurance coverage is already generally available;
- If coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;
- The level of public demand for the treatment or service;
- The level of public demand for individual or group insurance coverage of the treatment or service;
- The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts; and
- The impact of indirect costs (costs other than premiums and administrative costs) on the question of the costs and benefits of coverage.

The financial impact requirements include the extent to which the proposal would increase or decrease the cost of the treatment or service; the extent to which the proposed coverage might increase the use of the treatment or service; the extent to which the mandated treatment or service might serve as an alternative for a more expensive treatment or service; the extent to which insurance coverage of the health care service or provider can reasonably be expected to increase or decrease the insurance premium and administrative expenses of the policyholders; and the impact of proposed coverage on the total cost of health care.

State Employee Health Benefit Plan Study. KSA 40-2249a, enacted by the 1999 Legislature, provides, in addition to the impact report requirements, that any new mandated health insurance coverage approved by the Legislature is to apply only to the state health care benefits program for a period of at least one year beginning with the first anniversary date of implementation of the mandate following its approval by the Legislature. On or before March 1, after the one-year period has been applied, the State Employee Health Care Commission is to report to the President of the Senate and the Speaker of the House of Representatives the impact the new mandate has had on the state health care benefits program, including data on the utilization and costs of the mandated coverage. The report also is to include a recommendation whether such mandated coverage should be continued by the Legislature to apply to the state health care benefits program or whether additional utilization and cost data are required.

Recent Interim Study

1998 Interim. During the 1998 Session, mandated coverages for prostate cancer screening and diabetes education were enacted. Additional legislation proposing new mandates also was introduced during the 1997-98 biennium but was assigned to the Special Committee on Financial Institutions and

Insurance, a 1998 interim study committee. In addition to the cost estimates provided by those requesting consideration for mandate proposals, the Committee requested impact statements on premiums for the mandates from the Kansas Department of Health and Environment, as the statistical agent for the Kansas Insurance Department, using the data in the Kansas Health Insurance Information System (KHIIS). The provisions of the bills for proposed mandates were used by the actuary to determine the impact.

In its final report to the 1999 Legislature, the Committee recommended: that coverage for reconstructive breast surgery and coverage for certain oral dental procedures (for young children and certain persons who are severely disabled or have medical or behavioral problems) be mandated by the 1999 Legislature; that point-of-service issues be studied further, perhaps by the House Committee on Insurance early in the 1999 Session; and that no action be taken to mandate coverage for durable medical equipment or to provide parity for mental illness conditions. Other proposed mandates–maternity benefits, infertility treatments, and certain patient protections–were not recommended. The Committee also recommended any new mandate enacted after the effective date of any enactment by the 1999 Legislature (KSA 40-2249a) be applied first to state employees under the state employee health benefit plan prior to being applied to the public health insurance marketplace.

2003 Interim. The 2003 Special Committee on Insurance also reviewed existing mandates, hearing from both opponents and proponents, reaching a consensus that there was no need to change existing mandates.

The Committee also reviewed proposed mandated coverages from the 2003 Session for contraceptives, cancer clinical trials, and common therapies utilized in early intervention of developmental disabilities. A hearing was scheduled to allow for the review of a hair prostheses bill; however, the scheduled conferee cancelled the presentation, and the Committee gave no further consideration to the topic.

In its final report to the 2004 Legislature, the interim Committee recommended that, as new mandates are proposed in the future, those proposing the mandates be required to meet the current law requiring impact studies to be completed and presented to the Legislature before consideration is given to the issue.

Mandates in Kansas and Other States

The Kansas Legislature has enacted eight provider mandates and 14 mandates to provide certain benefits or to cover certain health conditions. In contrast, as of 2005, Maryland had more than 52 mandates and California had 46 mandates in place. Other states, including Connecticut, Florida, and Minnesota, also had more than 40 mandates in place. Using this comparison of state mandates, Kansas is closer to its neighbors in having 25 and 36 mandates. (Note: the number of Kansas mandates, outlined in a December 2005 Blue Cross and Blue Shield Association comparison report of state mandates, varies from the figures provided above by rating Kansas with 15 provider mandates and 15 benefit mandates. The increase is due to interpretation of state laws and definitions assumed for mandated coverages.)

Mandates adopted by Kansas correspond with what most other states and the District of Columbia have enacted, as indicated in the following table. The table also includes benefit mandates that were most recently considered by the Legislature.

Table B - Comparison of State Mandates*

Provider Mandates	States		Benefit Mandates	States
Chiropractors	47		Alcohol Treatment	45
Dentists	42		Drug Abuse Treatment	33
Optometrists	46		Mammography Screening	50
Nurse Practitioners	33		Mental Health (Parity)	33
Podiatrists	38		Minimum Maternity Stays	51
Social Workers	**28**		Prostate Cancer Screening	27
Marriage Therapists	**16**		Diabetes Supplies and Education	47
Professional Counselors	**18**		Emergency Services	45
			Breast Reconstruction	51
			Hair Prostheses (Wigs)	6
			Contraceptives	25
			Dental Anesthesia	27
			Bone Density Screening	15
			Clinical Trials	**18**
			Ambulance Transportation	**9**
			Colorectal Screening	**24**
			Hearing Aids	**7**
			Infertility Treatment	**14**
			Telemedicine	**5**

Source: State Mandated Benefits and Providers, Blue Cross and Blue Shield Association, December 2005

***Highlighted** provider and benefit madates are under current review (legislation introduced during the 2007 Session). The Social Workers mandated benefits law is under review for inclusion of other professional groups licensed by the Behavioral Sciences Regulatory Board. Separately, mental health coverage limitations are under review.

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KAMU

Kansas Association
for the
Medically Underserved
The State Primary Care Association

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Testimony on:
Informational Briefing and Overview on:
Safety Net Clinics

Presented to:
Senate Public Health & Welfare Committee

By:
Cathy Harding
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SENATE PUBLIC HEALTH AND WELFARE
DATE: 01/23/08
ATTACHMENT: 3

Mr. Chairman, members of the Committee, I am Cathy Harding, Executive Director of the Kansas Association for the Medically Underserved, also known by the acronym KAMU. KAMU's membership is comprised of 33 organizational and four associate members, all of which provide health services to low-income individuals regardless of ability to pay. This afternoon, I would like to briefly describe the role that Kansas safety net clinics currently play in the health care system and then talk a little bit about the role that we think the safety net clinics can play in health reform.

Let me start by spending a couple of minutes describing the population we serve. Ninety-two percent of our patients have incomes below 200 percent of the federal poverty level. "Federal poverty level (FPL)" is a term that is used quite often in health care policy discussions. To give it some context, the median income in the United States falls in the range between 325 and 350 percent of poverty. So, people with incomes below 200 percent of poverty have incomes that are less than 60 percent of the median income. These are the people who are most at risk of being uninsured or underinsured. Among them, approximately 30 percent of people with incomes below 100 percent of poverty and 20 percent of people between 100 and 200 percent of poverty have no private *or* public health insurance. To put those statistics into perspective, in our state this means there are 173,562 uninsured Kansans under the age of 65 who live in families with incomes below 200 percent of poverty (U.S. Census Bureau estimates).

As I said, these are the people we treat. Sixty-thee percent of all of our patients have incomes below 100 percent of poverty; 29 percent have incomes between 100 and 200 percent of poverty. Only thirteen percent of our patients have private insurance. Approximately 20 percent have either Medicaid or HealthWave, 11 percent have Medicare coverage, but 56 percent have no insurance at all. (Graph)

Many low-income people have chronic conditions, such as diabetes, asthma, and hypertension. The safety net clinics of Kansas attempt to help these patients manage their health care in a medical home. "Medical home" is a term you will no doubt hear a lot this session. I won't spend a great deal of time describing the concept today, but I will say that the safety net clinics endorse the medical home model and have been moving to implement the model for several years. We provide comprehensive primary care services which emphasize prevention and chronic disease management using approaches developed by the Institute for Health Care Improvement. In many cases, we offer integrated primary, oral and behavioral health services. We create sustained relationships between patients and caregivers. We provide enabling and supportive services – such as translation, transportation, and other culturally appropriate services – that promote health literacy and help improve outcomes.

And we have been growing. In 2004, we provided services to roughly 121,000 patients (333,000 visits). In 2006, the most recent year for which we have data, we provided care to 166,000 unduplicated users (426,000 visits) – an increase of 37 percent in two years.

That's who we have been treating, but who *aren't* we treating? Let's focus exclusively on the low-income uninsured. We estimate that in 2006 we saw approximately 93,000 uninsured patients. This is 54 percent of the 176,562 low-come uninsured Kansans estimated by the

Census Bureau. This means, of course, that there some 46 percent of the low-income uninsured were not seen in our clinics.

Some of these individuals were no doubt in good health and, arguably, did not require medical or dental services. But some did. The consequences of under-service are profound. First of all, there is the cost to the individual in terms of untreated disease and disability. But there are also costs to the system. Just because a person does not have insurance, does not mean that he or she does not receive services. Typically, a person who does not have insurance and who lacks a usual source of care will delay care until an acute episode occurs and then will go to the place that is always open and where he or she will always be seen, regardless of ability to pay – the hospital emergency department. The Hospital ED is an expensive source of care. Sometimes, the conditions are so acute that the person has to be admitted. The hospital is a *very* expensive source of care.

In 2003, the U.S. Agency for Healthcare Research and Quality published a report on avoidable hospitalizations. The study examined what are called ambulatory care sensitive conditions – conditions for which timely and effective ambulatory care can help prevent or avoid the need for hospitalization. Examples of ambulatory care sensitive conditions are asthma, diabetes, hypertension, bronchitis, gastroenteritis, and pneumonia. Kansas was one of the states that provided data to the study. The study calculated expected hospitalization rates for these conditions and compared them to actual rates for the states that contributed data. Here is what they found: the observed hospitalization rate in Kansas for the marker conditions was 21.4 percent greater than expected in the 0-17 years of age cohort; the Kansas rate was 22.8 percent higher for the 18-39 years of age cohort; and 8.5 percent higher for the 40-64 years of age cohort. The difference between the expected rate and the Kansas observed rate can be considered avoidable hospitalizations.

The costs resulting from avoidable hospitalizations are generally charged to charity or written off as bad debts by the hospital. But these services are not provided free of cost. Someone has to pay this cost. In practice, these costs are shifted to the people who pay charges or marginally discounted charges – in other words commercially insured patients. These avoidable hospitalizations make costs higher for insured patients and premiums more expensive for all Kansans with health insurance.

The people most likely to not receive timely and effective primary care services are those who have low incomes, no insurance, and no regular source of care. The most humane and cost effective way of avoiding these expensive and unnecessary hospital admissions is to care for these patients in primary care medical homes. One study estimates that for every dollar spent on care provided in a safety net clinic, at least three dollars is saved on more expensive care elsewhere in the system.

Unfortunately, after years of growth, the capacity of the safety net in Kansas is growing thin. In order to care for substantially more patients, it is necessary to recruit new doctors and dentists, employ more nurses and lab techs, purchase new equipment, expand our physical capacity, and open new clinics in areas of the state where they are needed but do not now exist.

Because the safety net clinics do not have many patients with health insurance, we cannot finance increases in the number of uninsured patients we see by shifting costs – there is no place to shift costs. We must rely on the good will of benefactors and volunteers who donate money and time to our clinics. The Legislature in recent years has also been very generous to the safety net. These sources of public and private funds have permitted the safety to grow. To serve more patients and make the kinds of needed changes to the safety net infrastructure we need to ask for you help again.

To develop the infrastructure that allows the safety net to more effectively care for underserved Kansans in the future we believe these four components are essential:

Funding for workforce development so that adequate numbers of providers are available for safety net clinics to serve a greater number of patients. An investment in recruitment for dental and medical providers is needed.

Technology development/enhancement will result in greater efficiency, which will translate into increased capacity to serve more people. KAMU is beginning discussions with private funders about resources to implement Electronic Health Records for our members.

Funding for capital financing will help clinics build their capacity by acquiring the facilities, furnishings, equipment, and inventories of drugs and supplies they require. Most safety net clinics cannot afford substantial expansions, even if they are debt-financed. Therefore, KAMU recommends creation of a state safety net clinic capital grant program.

Funding to increase the capacity to provide technical and growth assistance for non-federally funded safety net clinics. Somewhat unique among state Primary Care Associations, KAMU's membership includes 22 clinics that receive no federal funds. Although KAMU receives a federal grant of more than $500,000 annually, these dollars are earmarked for assistance to federally funded health centers (numbering 11) and some limited community development to increase the number of clinics who receive federal funding. In order to provide state-funded clinics with the support they need to achieve the growth projected through this proposal, KAMU must increase its staff capacity to provide training and assistance for these clinics. Specific efforts will be in these areas of assistance:

- **Community and facility planning** – to expand the safety net geographically to reach all areas of need.
- **Organizational development** – to improve the internal efficiency of safety net clinics to make limited funds stretch further.
- **Clinic finance and management systems** – to assist clinics to develop the tools necessary to become sustainable.
- **Clinical and administrative quality improvement programs** – to develop the systems, metrics, and culture necessary to operate in a continuous quality improvement environment.

We also recommend that in the next year we improve our effort to enroll people in Medicaid and HealthWave who are currently eligible. Enrolling them will reduce the number of uninsured people and improve their access to health services. We want to help enroll these eligible people, and have two proposals to do that. First, station eligibility workers at safety net clinics with the

exclusive purpose of enrolling individuals in the health insurance programs for which they are eligible. Second, we suggest that the current presumptive eligibility experiment in Sedgwick County be expanded by five sites. Presumptive eligibility treats low-income people who present for care at clinics as if they already have Medicaid, pending their formal determination.

Finally, we believe that the current safety net has the capacity to absorb an increase of between 10 to 20 percent in the number of uninsured users, contingent upon the availability of funding to finance the extra services. An increase of this size would provide service to between 9,444 and 18,889 new uninsured Kansans.

Our ability to provide health services to underserved Kansans is limited not by our desire nor by our will, but by the capacity of the safety net. We need your help to allow us to serve more patients today and to prepare to care for even more patients tomorrow. Promoting the safety net clinics alone will not solve all of the problems of health care delivery and financing in Kansas. But it will make a significant, cost-effective contribution to moving people from the roles of the uninsured to public health insurance programs for which they are currently eligible. By increasing the capacity of safety net clinics to treat more uninsured persons, we not only provide needed services to them, but we avoid the costs of excess emergency department use and unnecessary hospitalizations. Mr. Chairman, members of the Committee, I would be pleased to answer any questions you might have.

KAMU

Kansas Association for the Medically Underserved

The State Primary Care Association

Providing a Medical Home

Who the Kansas Safety Net Serves

The primary care safety net clinics in Kansas care for all patients regardless of their ability to pay.

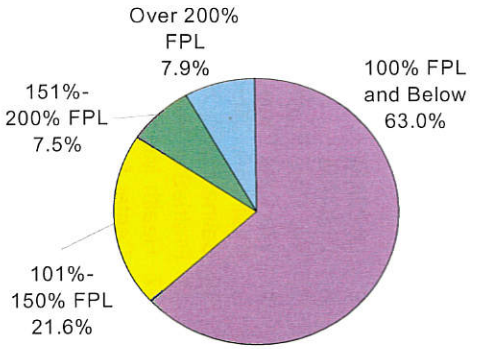
Many clinics provide a true medical home through integrated medical, dental and behavioral health services.

Statewide Clinic Use in 2006

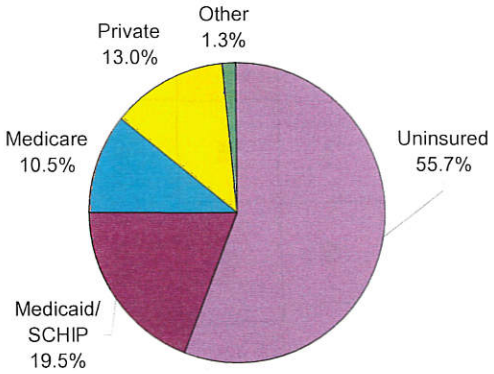
Total Patients	**166,233**
Total Visits*	**425,900**
Medical Visits	354,160
Dental Visits	55,631
Behavioral Health Visits	13,040

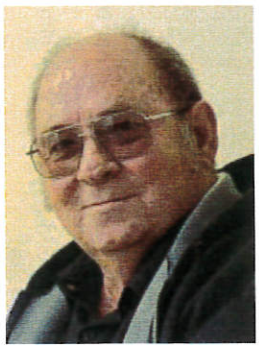
*Other supportive services are included in the total.

Statewide 2006 Patient Income Level Percent of Federal Poverty Level

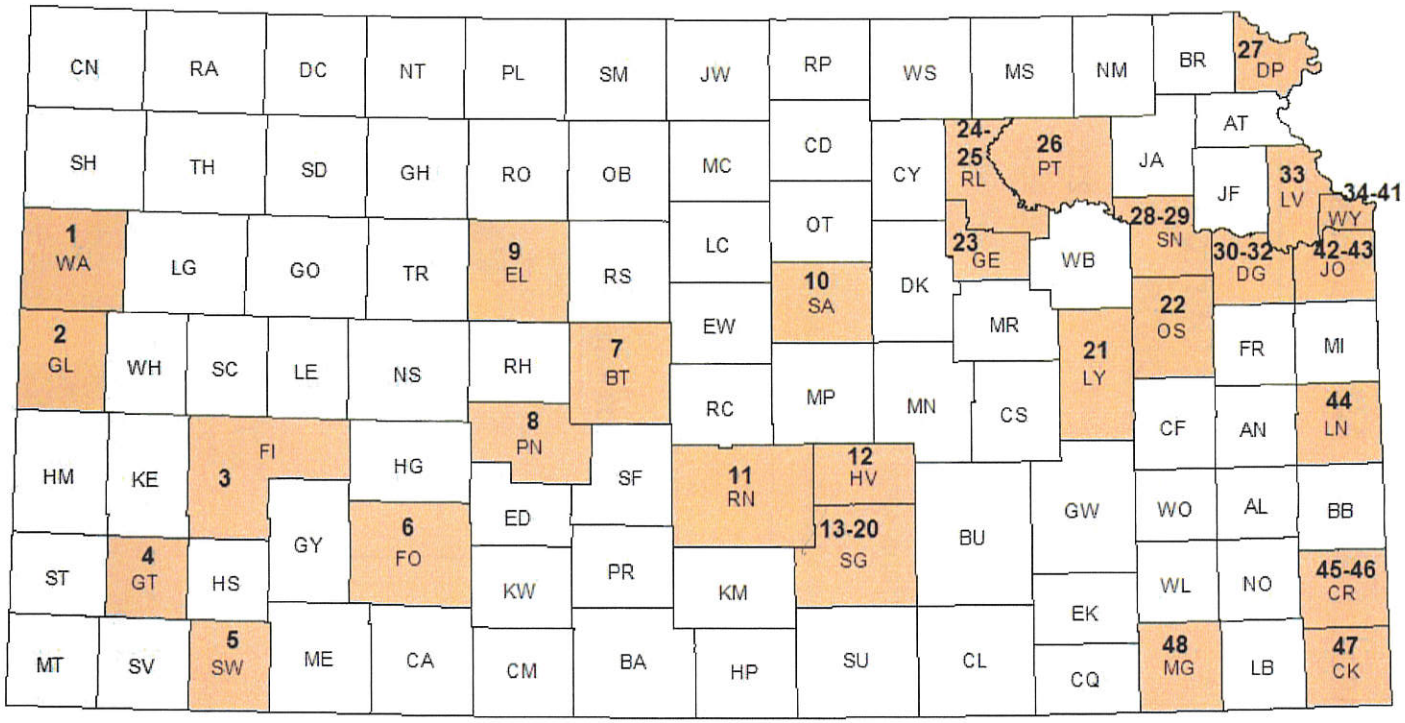


Statewide 2006 Patient Insurance Status





Kansas Primary Care Safety Net Clinics and Satellite Locations 2008



Clinics with locations in more than one county are identified in each county served. If a clinic has multiple sites in its home county, the number of sites is indicated in parentheses.

Statewide: The Kansas Statewide Farmworker Health Program has 117 access points.

1 Wallace/Greeley County Health Services
2 Wallace/Greeley County Health Services
3 United Methodist Mexican-American Ministries, Inc. (UMMAM)
4 UMMAM
5 UMMAM
6 UMMAM
7 We Care Project, Inc.
8 We Care Project, Inc.
9 First Care Clinic of Hays
10 Salina Family Health Care Center
11 PrairieStar Health Center
12 Health Ministries Clinic
13 Center for Health & Wellness, Inc.
14 Good Samaritan Health Ministries
15 GraceMed Health Clinic, Inc. (3)
16 Guadalupe Clinic, Inc. (2)
17 Healthy Options for Kansas Communities
18 Hunter Health Clinic (5)
19 Mother Mary Anne Clinic
20 St. Mark, E.C. Tyree Health Clinic
21 Flint Hills Community Health Center
22 Flint Hills Community Health Center
23 Konza Prairie Community Health Center
24 Riley County Community Health Clinic
25 Flint Hills Community Clinic
26 Community Health Ministry Clinic (2)
27 Wathena Medical Center
28 Marian Clinic (2)
29 Shawnee County Health Agency (3)
30 Douglas County Dental Clinic
31 Health Care Access
32 Heartland Medical Clinic
33 Saint Vincent Clinic
34 Children's Mercy West, The Cordell Meeks, Jr. Clinic
35 Community Health Council of Wyandotte County
36 Duchesne Clinic
37 KU Health Partners/Silver City Health Center
38 Mercy and Truth Medical Missions (2)
39 Southwest Boulevard Family Health Care
40 Swope Health, Wyandotte and Quindaro (2)
41 Turner House Clinic for Children
42 Health Partnership Clinic of Johnson County (2)
43 Mercy and Truth Medical Missions
44 Mercy Health Systems: Pleasanton Rural Health Clinic (RHC)
45 Community Health Center of Southeast Kansas (3)
46 Mercy Health Systems: Arma RHC
47 Community Health Center of Southeast Kansas (2)
48 Mercy Health Systems: Cherryvale RHC

KANSAS

DEPARTMENT OF HEALTH
AND ENVIRONMENT

Division of Health

Kathleen Sebelius, Governor
Roderick L. Bremby, Secretary

www.kdheks.gov

Testimony on
KDHE PRIMARY CARE CLINIC PROGRAM
Presented to
the Senate Public Health and Welfare Committee
by
Barbara Gibson, Director, State Primary Care Office
January 23, 2008

Mr. Chairman, members of the Committee, my name is Barbara Gibson. I am director of the Primary Care Section within the Office of Local and Rural Health. I am pleased to appear before you today to provide information about the state's primary health care safety net and to report on performance of the state-supported clinics and health centers.

BACKGROUND: Primary care clinic programs vary widely in terms of mission, service area, range of services, client eligibility, and local project goals and objectives. During 2004, state-funded clinics reported serving 73,165 individual patients with 190,961 clinic appointments. State support for the clinics that year was $1.5 million. Federal support was approximately $6.8 million.

For SFY2008, the Legislature added $2 million dollars for grants to clinics that make up the state's health care safety net. Of that amount, $750,000 dollars were appropriated for establishment of prescription drug assistance programs and federal Section 340B pharmacy projects, and $500,000 were earmarked for establishment or expansion of dental programs described as "dental hubs." The competitive grants were awarded to support operating costs and to provide funding to establish or expand access to primary health care, including dental and mental health services, for vulnerable and underserved Kansans. State support for the clinics this year is $5.2 million. Federal support is $7.5 million. Philanthropic support for dental hubs is over $2.5 million.

Thirty-one state funded clinics reported caring for 127,647 individual medical patients in 2006. Of that total, 61% or 78,189 were uninsured. If the new Kansas estimates of uninsured are around 300,000, that means the state-funded clinics are now serving approximately 25% of the uninsured. In 2002, we estimated that our support went toward services for 10% of those who were uninsured. Recent expansions and new clinics, supported by additional state, federal and foundation dollars, have allowed the safety-net to play a much larger role for the uninsured.

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Our clinics and health centers now provide care from clinical locations in over 25 counties. Using the most recent county-level Census estimates of the uninsured (302,304 Kansans), we find that 242,000 uninsured Kansans live in counties with a state-supported primary care clinic. Only 60,304 uninsured Kansans live in counties that lack a safety-net clinic.

Over the past twenty years, KDHE has periodically developed primary health care access plans that defined our highest priority areas based on criteria that rate counties and regions based upon poor health care access and lower health status. If the Agency had phased in a well-targeted geographic expansion plan, we could not have done much better. Projects emerged in the high-need areas with a significant number of underserved patients because local community leaders responded to locally identified problems. Public health data substantiated their observations and attracted resources including federal and state grants, charitable donations and foundation grants.

In 2006, 58,475 (or 75%) of the 78,189 uninsured patients were cared for in the fifteen largest clinics. The remaining 20,000 are seen in the other sixteen clinics. Among the thirty-one funded clinics, seven have a defined charitable mission and purpose to serve only low-income persons who are uninsured. These clinics serve approximately 10,000 patients, all of whom are uninsured.

Our public health objective is access to necessary health care for all Kansans. KDHE works with a network of primary care clinics to make this care available, accessible and affordable. The Kansas Health Policy Authority (KHPA) has expressed support for the "medical home" concept which is a key characteristic of the delivery model for safety-net clinics. KHPA reform recommendations also call for expansion of health insurance coverage to ensure better access to health care. By directing the state medical assistance programs and proposing health insurance expansions, we can work together to find the best way to finance and deliver care for more people. It is important that we implement both strategies.

FUTURE PROSPECTS FOR SAFETY-NET CLINICS: In a briefing to the Joint Health Policy Oversight Committee in December, we offered several ideas for aiding the work of community-based primary care clinics and Federally Qualified Health Centers (FQHC) including options for financial and non-financial support.

While the clinics serve as a safety net for the uninsured, they are also the "medical home" for other low-income or underserved persons including those covered by Medicare and HealthWave who cannot find a private provider in the health care marketplace. We are appreciative of having the "medical home" concept featured in the twenty-one KHPA reform recommendations. The cost-based reimbursement method of Medicaid payment to FQHCs acknowledges the extra costs of being a medical home and allows these expenses to be part of the cost report.

The primary care medical home coordinates patient-centered care and individual health care planning. Community-based primary care set goals to make this happen. The service protocols for patients of these clinics are strongly oriented toward improvement of health literacy, prevention instruction, nutrition and fitness, tobacco avoidance, smoking cessation, and case management, as well as early and regular screening for cancer and chronic diseases.

Last week, KDHE mailed and posted electronically the Primary Care Clinic Grant Application Guidelines for the coming state fiscal year. A web-based pre-application conference is scheduled for February 6. At that time, we will answer questions about the state grant

application process and how it will be coordinated with the foundations grant awards process for expansion and growth of dental hubs. In the conference we will also explain how to develop health and business plans to guide and improve service quality, fiscal management and operational capacity. Clinics will be offered technical assistance to address some of the health promotion, disease prevention objectives included in the KHPA 21 reform recommendations on nutrition, tobacco avoidance and fitness. The will also be instructed on how to select several appropriate health outcome measures from Healthy People and Healthy Kansans 2010.

With financial and technical support from health foundations and the state, twenty clinics and health centers have now integrated oral health services into their primary care service delivery model. They are on the front line treating dental disease in persons who are uninsured and those having dental benefits under Medicaid and HealthWave. Clinics are supported indirectly when more Kansans obtain affordable health insurance and more eligible children are enrolled in HealthWave. The safety net would also benefit if adequate Medicaid payments were available for adult dental services, or at least for pregnant women. If the state extended dental benefits to pregnant women under the Medicaid program, it would not only reduce some of the avoidable complications of pregnancy attributed to dental disease, but also provide better reimbursement to those clinics now providing discounted or free dental care to pregnant women. Finally, coverage for smoking cessation programs and out-stationed eligibility workers would also be welcomed.

For nearly a decade, the funding for clinics was essentially level. Efficiencies in clinic management and other fiscal partners permitted slow but steady growth during that time. Each year since 2005, the clinic program has received an increase in funding. However, the current network of clinics could only reasonably expect to increase their capacity modestly through efficiencies alone. To serve additional patients, including the uninsured, the currently funded clinics would need grant increases for service expansion or new sites. To reach new areas of the state, new community-based projects would need to be developed and funded.

The average planning, development, and start-up period for locally-organized clinics is from eighteen to thirty-six months. We can assume that communities with the most resources for project development and implementation have already established clinics for their underserved populations. Future clinic development may occur in areas that will require even more time and technical assistance to become operational.

With last year's grant increases, clinic and health center directors have struggled to recruit the health professionals that are required to provide the additional medical and dental services. KDHE assists the clinics by consulting on the recruitment of National Health Service Corps scholars and in application for state or federal loan repayment assistance. The FQHCs currently have twenty-seven vacancies eligible for state and federal loan repayment: twelve medical, eleven dental and four mental health professionals. Many clinics are at a recruitment disadvantage because they offer salaries well below the private sector. The loan repayment assistance helps compensate for that disadvantage.

Another recruitment resource is the J-1 visa waiver review program, known as the Conrad/State 30 Program. KDHE also uses the authority as state public health agency to recommend waivers to visa obligations for foreign physicians willing to serve in HPSAs. In recent years, several state-funded clinics have used this method for recruitment of primary care physicians. The most recent is to staff the Dodge City clinic operated by United Methodist Mexican American Ministries with a physician fluent in Spanish and English. There are no fees associated with application process and there is no state or federal funding for the program.

In this year's clinic funding, KDHE designated $150,000 for state loan repayment assistance to professionals willing to practice for one year in a non-profit or safety-net sites located in federal Health Professional Shortage Areas (HPSA). In this grant cycle, we again propose $150,000 for the loan repayment assistance program. At this point, we will increase the agreement from a one year to a two year service obligation. With state funding available, we expect that KDHE will be in a better position to receive a matching amount from the federal grant program supporting state loan repayment assistance programs.

Finally, as the clinics and health centers integrate mental health services into their combined medical and dental programs, we have a number of professionals licensed by the Behavioral Sciences Regulatory Board who wish to volunteer their part-time services and participate in the Charitable Health Care Provider Program. The law allows specified provider groups to register with the KDHE Secretary and be covered by the protection of the Kansas Tort Claims Act. Medical, dental and nursing professionals are eligible. Mental health providers have not been included. Last year House Bill 2239 was introduced to include these providers in the program. The inclusion of mental health professionals licensed at the independent clinical level would be useful to clinics that begin their programs using volunteers. We understand that some revisions might be required to the original bill before it would be considered this year.

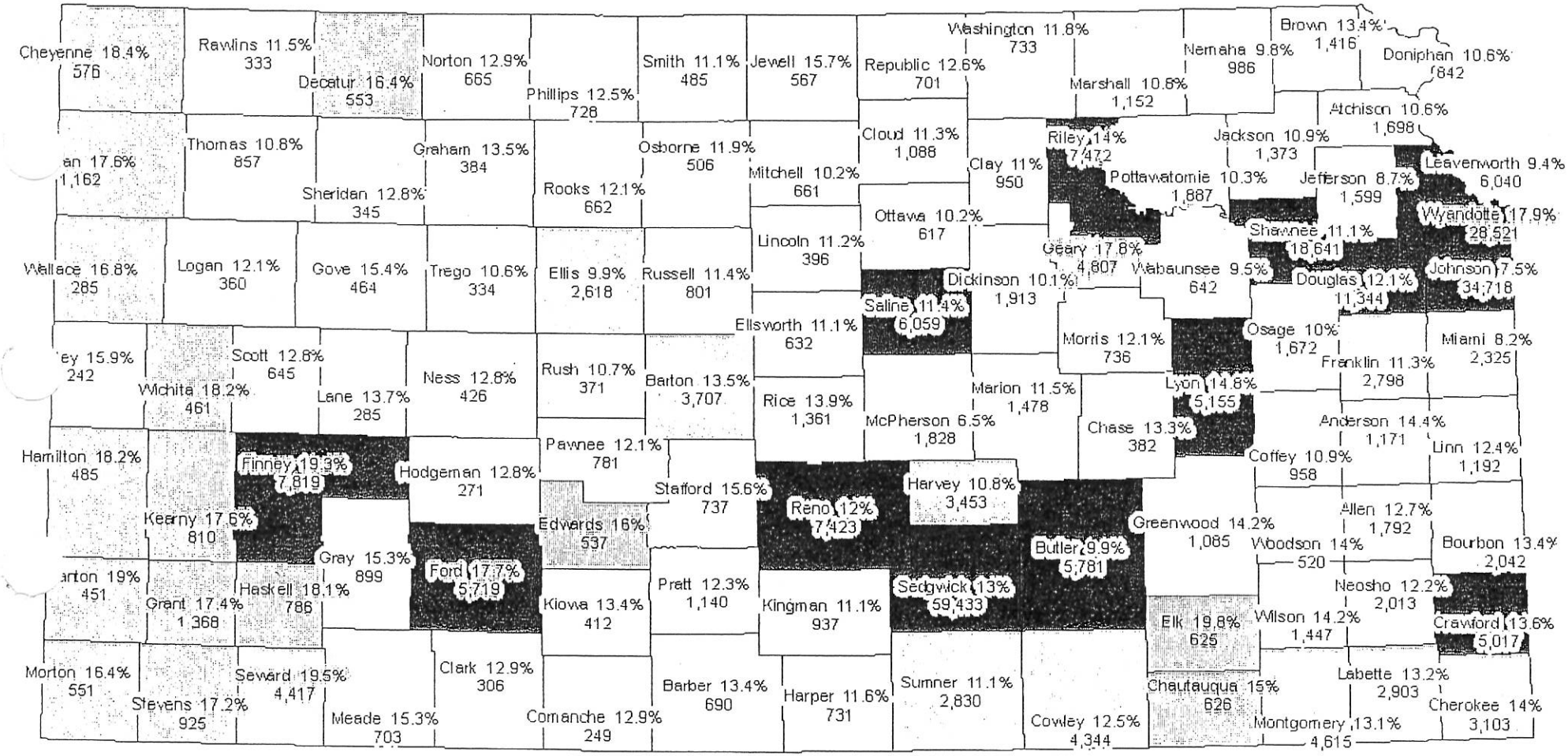
Thank you for the opportunity to appear before this Committee. I will be happy to respond to any questions you may have.

Health Insurance Coverage for Kansas Counties, 2000: Experimental Estimates

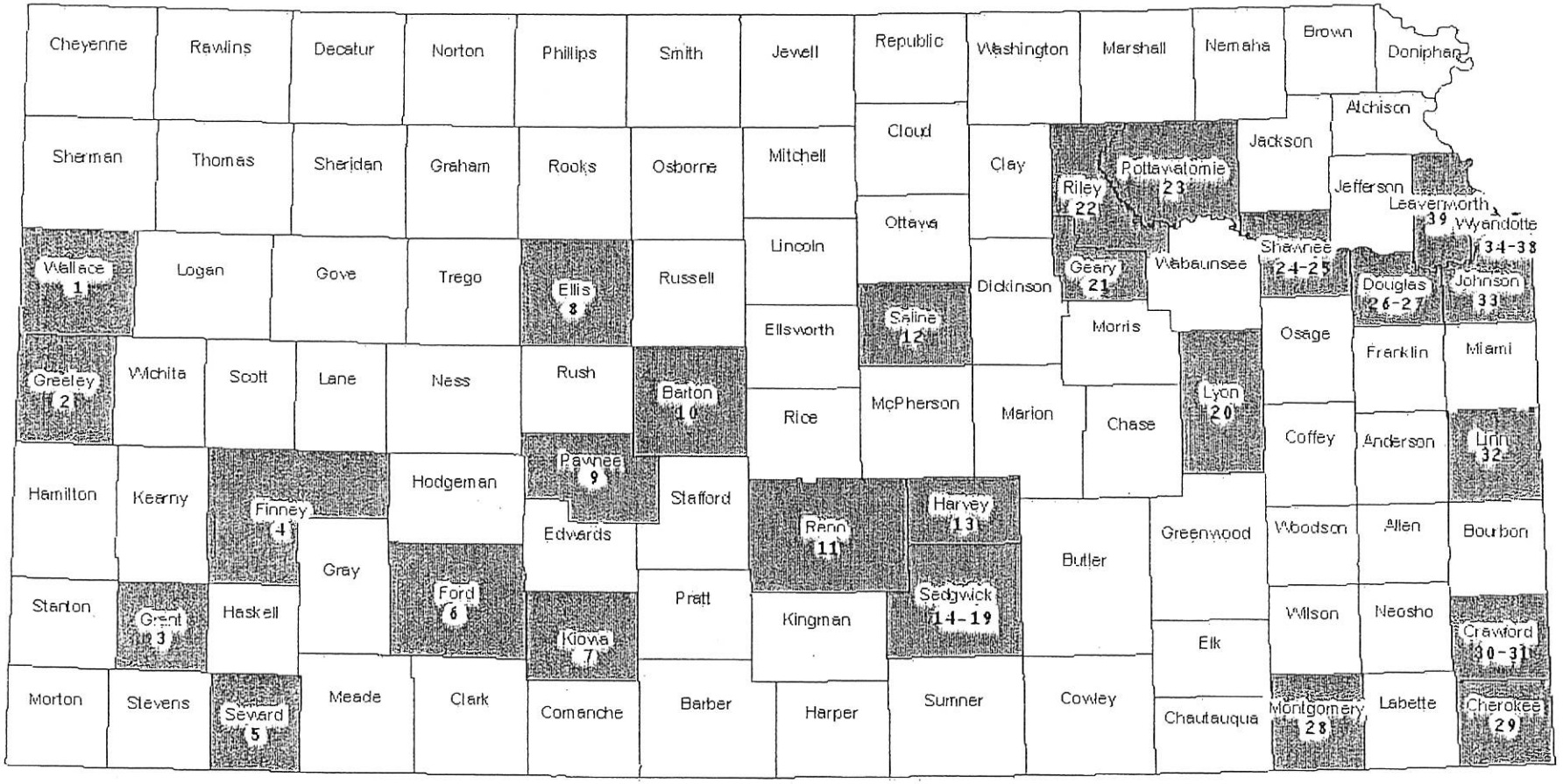
Kansas All Ages

Source: U.S. Census Bureau, Housing and Household Economic Statistics Division, Small Area Estimates Branch

http://www.census.gov/cgi-bin/hhes/sahie/sahie.cgi http://www.census.gov/hhes/www/sahie/methods/methods.html



State-Funded Primary Care Clinic Grant Programs: SFY 2008



1 Wallace County Family Practice Clinic
2 Greeley County Family Practice
3 United Methodist Mexican-American Ministries
4 United Methodist Mexican-American Ministries
5 United Methodist Mexican-American Ministries
6 United Methodist Mexican-American Ministries
7 Kiowa County Hospital, Rural Health Clinic
8 First Care Clinic of Hays
9 We Care Project, Inc.
10 We Care Project, Inc.
11 PrairieStar Health Center
Salina Family Health Care Center
13 Health Ministries Clinic
14 Tyree Health & Dental Clinic, E.C.
15 Center for Health & Wellness
16 Good Samaritan Health Ministries
17 GraceMed Health Center, Inc.
18 Guadalupe Clinic, Inc.
19 Hunter Health Clinic
20 Flint Hills Community Health Center
21 Konza Prairie Community Health Center
22 Riley County Manhattan Health Department
23 Community Health Ministry Clinic
24 Marian Clinic
25 Shawnee County Health Agency
26 Heartland Medical Clinic Inc.
27 Health Care Access, Inc
28 Montgomery County Community Clinics
29 Community Health Center of Southeast Kansas
30 Community Health Center of Southeast Kansas
31 Mercy Health System (RHC Arma)
32 Mercy Health System (RHC Pleasanton)
33 Health Partnership Clinic of Johnson County
34 Silver City Health Center
35 Turner House Clinic for Children
36 Swope Health Services
37 Southwest Boulevard Family Health Care
38 Caritas Clinics: Duchesne Clinic
39 Caritas Clinics: St Vincents