Approved: 05/02/08
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman James Barnett at 1:00 P.M. on April 3, 2008 in Room 136-N of the Capitol.

All members were present except:
Senator Peggy Palmer- excused
Senator David Haley - absent

Committee staff present:
Emalene Correll, Legislative Research Department
Terri Weber, Legislative Research Department
Nobuko Folmsbee, Revisor of Statutes Office
Renae Jefferies, Revisor of Statutes Office
Sara Zafar, Intern, Legislative Research Department
Margaret Cianciarulo, Committee Secretary

Conferees appearing before the committee:
Cathy Harding, Executive Director, Kansas Association for the Medically Underserved
Chris Tilden, Director, Local and Rural Health, Kansas Department of Health and Environment
Dr. Marcia J. Nielsen, Executive Director, Kansas Health Policy Authority

Others attending:
See attached list.

SB 697 - Funding recommended for primary care safety net clinics; appropriation recommended to KDHE and KHPA.

Senator Jim Barnett introduced pages, Sam Cheesebrough and Eli Kahn from Blue Valley School District.

Senator Barnett indicated the bill being heard today recommends funding for primary care safety net clinics through Kansas Association for the Medically Underserved and increased funding to established clinics for provision of direct care through the Kansas Department of Health and Environment.

Chairman Barnett recognized Cathy Harding, Executive Director for the Kansas Association for the Medically Underserved to speak in support of **SB 697.**

Cathy Harding referred to her presentation on January 23, 2008 in which a detailed presentation was provided to committee members relative to Safety Net Clinics. The purpose of these clinics is to serve those low-income residents and to ensure that safety net clinics will be ready and able to meet the needs of the future. This readiness of these clinics is contingent upon expanded resources and infrastructure development (Attachment 1):

Ms. Harding indicated that Safety Net Clinic revenue is generated by:

Net Patient Revenue	38.9%
Federal CHC Grants	19.6%
Other	18.7%
State Grants	12.0%
Private Foundation Grants	10.8%

Ms. Harding indicated that as the number of patients served in the clinics increases, it is necessary to expand non-patient sources of revenue to remain solvent because 60% of revenues do not vary according to patient volume. Ms. Harding requested funding (increased above **SB 697** current provisions) as follows:

Increased funding to clinics for provision of direct care (through KDHE)	$1,645,000
Infrastructure development to include:	
Workforce development (through KAMU)	75,000

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.

Capital financing (through KAMU)	700,000
Non-federal Clinic Technical Assistance (through KAMU)	80,000
Total Requested Funding	$2,500,000

Ms. Harding also detailed for committee members on-going efforts to collaborate with other agencies/sources, etc., to increase funding for the infrastructure component of the request.

Questions from Senators Wagle, Schmidt and Barnett relative to the correlation of monies received to numbers of clients served; federal funds and infusion of additional grants; physician recruitment (paid medical staff) as a component of the infrastructure development; cooperating with the Kansas Health Policy Authority for assistance in technological development; and issues related to the inability to secure adequate medical records for medically underserved Kansans when a hospital admission is required.

Chairman Barnett recognized Chris Tilden, director of the Office of Local and Rural Health, Kansas Department of Health and Environment who spoke in support of **SB 697** (Attachment 2). Mr. Tilden praised the work provided by safety net clinic professionals noting 25% of uninsured Kansans requiring medical care are seen in safety net clinics. Mr. Tilden reported funding applications are being received at this time. Currently-funded clinics have applied with increased funding requests to offset expense for new clients, an additional five clinics (not previously seeking state funding) have applied for funding, and two new applicants in northwest Kansas have applied for funding for new clinics not currently served by a safety net site. Mr. Tilden encouraged favorable passage of **SB 697**.

Dr. Marcia Nielsen, Executive Director, Kansas Health Policy Authority, was recognized to speak regarding **SB 697**. Dr. Nielsen spoke to the increase of uninsured Kansans, lower-income residents increase utilization of safety net clinics, and the role of safety net clinics as a critical access path to the health care system in Kansas for these uninsured and low-income individuals (Attachment 3). Dr. Nielsen also reported that KHPA reforms positively impact safety net clinics by promoting personal responsibility, defining medical homes with the implementation of statewide community health records to include insurance card standardization, as well as health prevention. In addition, statewide marketing for SCHIP, Medicaid, and premium assistance programs linking services to safety net clinics.

Senator Wagle questioned the relationship and coordination of care in safety net clinics to insurance plans provisions, i.e., managed care/HMO plans. Dr. Nielsen explained the conceptual framework of a medical home model as opposed to other models, and the importance of continuity and coordination of care and its functions as related to positive outcomes within various models.

Senator Barnett called committee members' attention to written testimony submitted by:

Amy Falk, Executive Director, Caritas Clinics, Inc. (Attachment 4)
Sally Tesluk, Executive Director, PrairieStar Health Center, (Attachment 5)
Marcie Strine, Interim Executive Director, United Methodist Mexican-American Ministries, Inc. (Attachment 6)

Ms. Folmsbee, Revisor of Statutes office, distributed a proposed amendment to **SB 697** that would increase funding to safety net clinics (Kansas Association for the Medically Underserved), Kansas Department of Health and Environment, and the Kansas Health Policy Authority. Discussion followed.

Senator Schmidt moved to recommend **SB 697** reflect increased funding as follows:

Increased funding to clinics for provision of direct care (through KDHE)	$1,645,000
Infrastructure development to include:	
Workforce development (through KAMU)	75,000
Capital financing (through KAMU)	700,000
Non-federal Clinic Technical Assistance (through KAMU)	80,000

Kansas Health Policy Authority:	
Web-based enrollment for children eligible for Medicaid	250,000
Dental care for pregnant women	550,000
Statewide community health record	384,000
Outreach	550,000
Total Recommended Funding Allocation	$4,234,000

and to favorably pass out **SB 697** as amended. The motion was seconded by Senator Jordan. The motion passed.

The meeting was adjourned at 1:45pm.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE GUEST LIST

DATE: April 3, 2008

NAME	REPRESENTING
J. Kiale	Federico Consulting
Allison M. Cheesebrough	Sunrise Pt. Elem. (O.P., KS) mother of page
Bill Sneed	UKHA
Mike Reecht	GBBA
Cynthia Smith	SCLHS
[illegible] Eli Kahn	Sunrise point page
Sam Cheesbrough 19	Sunrise Point page
[illegible]	KAHU
Reagan Cussimanio	KHPA
[illegible]	KHPA
Marcia J Nielsen	"
Gareth Fozell	KHI
Mike Shields	KHI News
Dan Morin	KS Medical Society
Chris Tilden	KDHE
Robert Stiles	KDHE
Tracy Russell	KHPA

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Senate Bill 697
Senate Public Health and Welfare Committee
April 3, 2008

Cathy Harding
Executive Director
Kansas Association for the Medically Underserved

Mr. Chairman, members of the Committee, for the record I am Cathy Harding, Executive Director of the Kansas Association for the Medically Underserved. Many of you have heard me talk this session about the safety net clinics in Kansas: who we are, where we are located, who we serve, and the role we play in the health care system in Kansas. Despite the fact that I am enormously proud of the clinics I represent and the job they do, I will respect your time today and be brief and to the point. The ability of the safety net clinics to continue to serve low-income residents of the state is contingent upon expanded sources of revenue on the one hand, and the development of infrastructure on the other.

Let me talk about both of these issues in the context of the bill before you. The safety net clinics receive funding from five sources: State grants, federal grants (for federally qualified health centers only), private foundation grants, patient revenues, and other sources, which includes gifts from individuals. In 2006, the last year for which we have complete statistics, 38 percent of all revenues were paid by patients directly or by their public or private insurance provider. The federal government contributed 20 percent of the funding of the safety net clinics, even though these funds were distributed to only one-third of our clinics. Nineteen percent came from other sources, mostly religious and private donations of funds. Eleven percent came from private philanthropic foundations in the state. And 12 percent came from state government grants.

The clinics are essentially break-even propositions. Consequently, the state grants play an important role in financing safety net services. Clearly, clinic expenses increase with patient volume: the more patients you see the more it costs. But the only source of revenue that varies with volume is patient revenue – and it only covers about 40 cents on the dollar of expenses. The state grants to safety net clinics have played an important role in recent years. They have helped fund the growth in patient services. In the last three years, we estimate that the number of safety net clinic users has grown by 53 percent. Two-thirds of this proposed $2.5 million increase in funding would go to fund direct care at the clinics. This level of funding would finance 16,450 patient visits for 6,092 users.

There will come a time, though, and it may not be too far off, when future increases in the ability to care for low income people in safety net clinics may come to an end unless meaningful investments are made in safety net infrastructure. We cannot treat more patients if there are not doctors and dentists to see them. We cannot efficiently move patients though our clinics if we do not have enough examination rooms and equipment, including health information technology. The safety net in Kansas currently has some

notable holes in it. We need to patch those holes. We have to plan for geographic and population expansions to serve low-income Kansans who are not currently served. This is what I mean by infrastructure development: creating the capacity today so that we can treat more patients tomorrow. We suggest that one third of the proposed expenditure be allocated to infrastructure development. Specifically, we would suggest earmarking $75,000 for provider recruitment and retention, $700,000 for capital financing for equipment and facilities, and $80,000 for technical assistance for facility planning and clinical and administrative quality improvement to squeeze more out of every dollar.

Mr. Chairman, members of the Committee, I greatly appreciate this opportunity to appear before you and share with you how we believe this money could best be spent. I have, of course, discussed this proposal with my members, and we believe it strikes a balance between addressing the health care needs of low income patients today and assuring that the safety net clinics of Kansas will be ready and able to satisfy those needs in the future. I would be happy to answer any questions you may have.

Building Medical Homes

Fact Sheet: The Kansas Safety Net

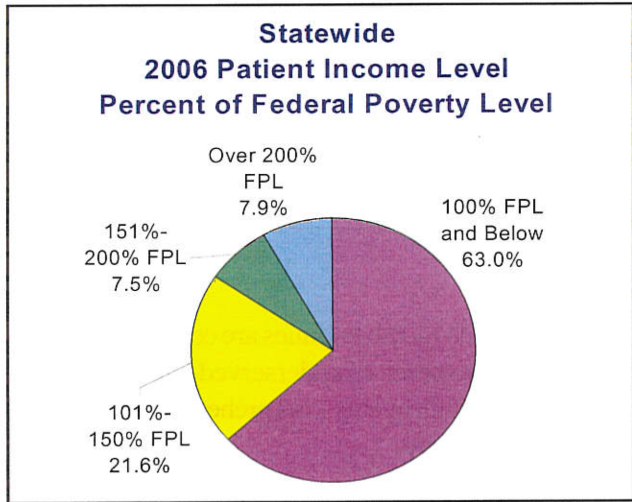
The primary care safety net clinics in Kansas care for all patients regardless of their ability to pay.

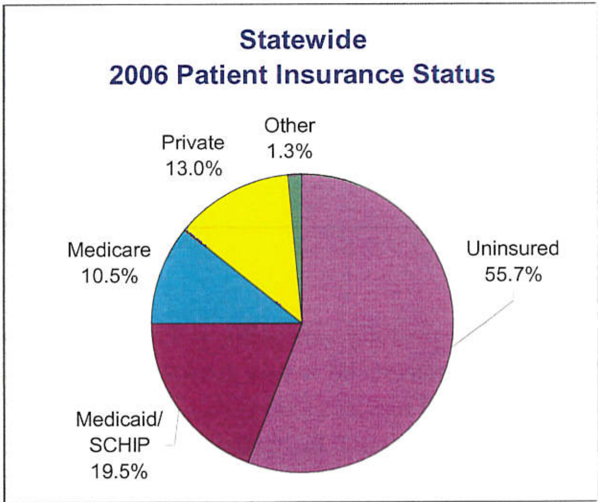
Some clinics provide a true medical home through integrated medical, dental and behavioral health services.

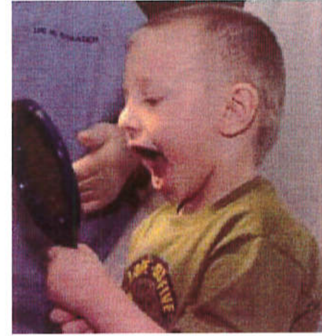
Statewide Clinic Use
(2006 Data)

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.







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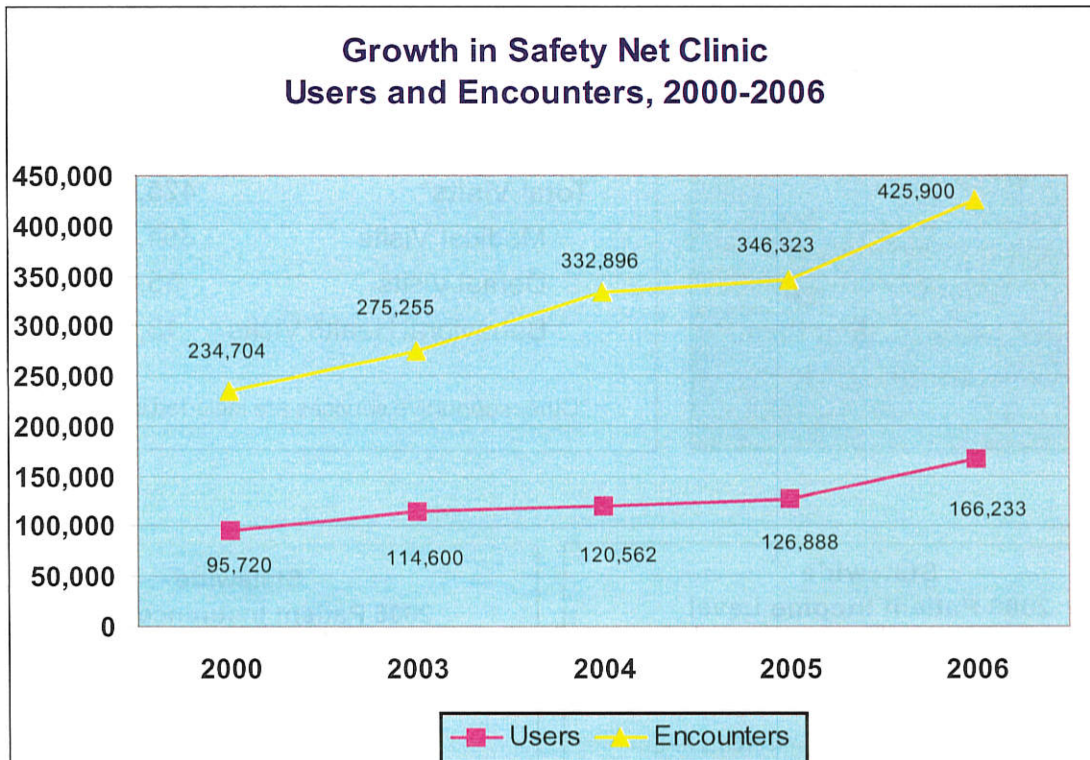
Kansas Association for the Medically Underserved
The State Primary Care Association

Building Medical Homes

Strengthening and Expanding the Primary Care Safety Net



The primary care safety net in Kansas has experienced steady growth. In 2004, we provided services to almost 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.

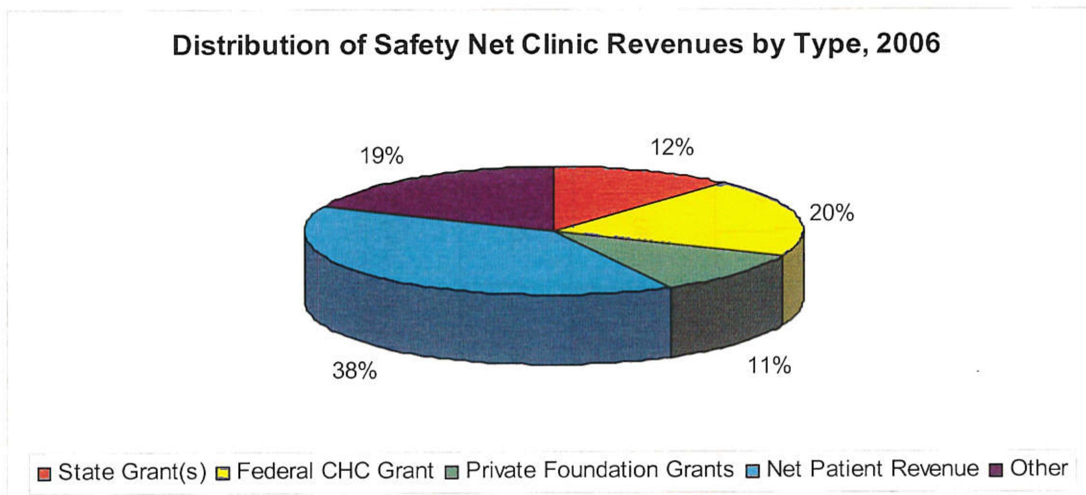
To attain this level of growth, the safety net clinics expanded their capacity by opening new sites, hiring more staff, and offering expanded services and hours of operation.

KAMU and its member clinics are committed to meeting the needs of underserved Kansans by providing high quality, comprehensive and cost-effective care.

To fulfill this commitment, we must continue to develop the infrastructure of the primary care safety net. *KAMU's 2008 Legislative Agenda* provides a plan for enhancing the capacity and long-term viability of the primary care safety net.

Financing the Safety Net

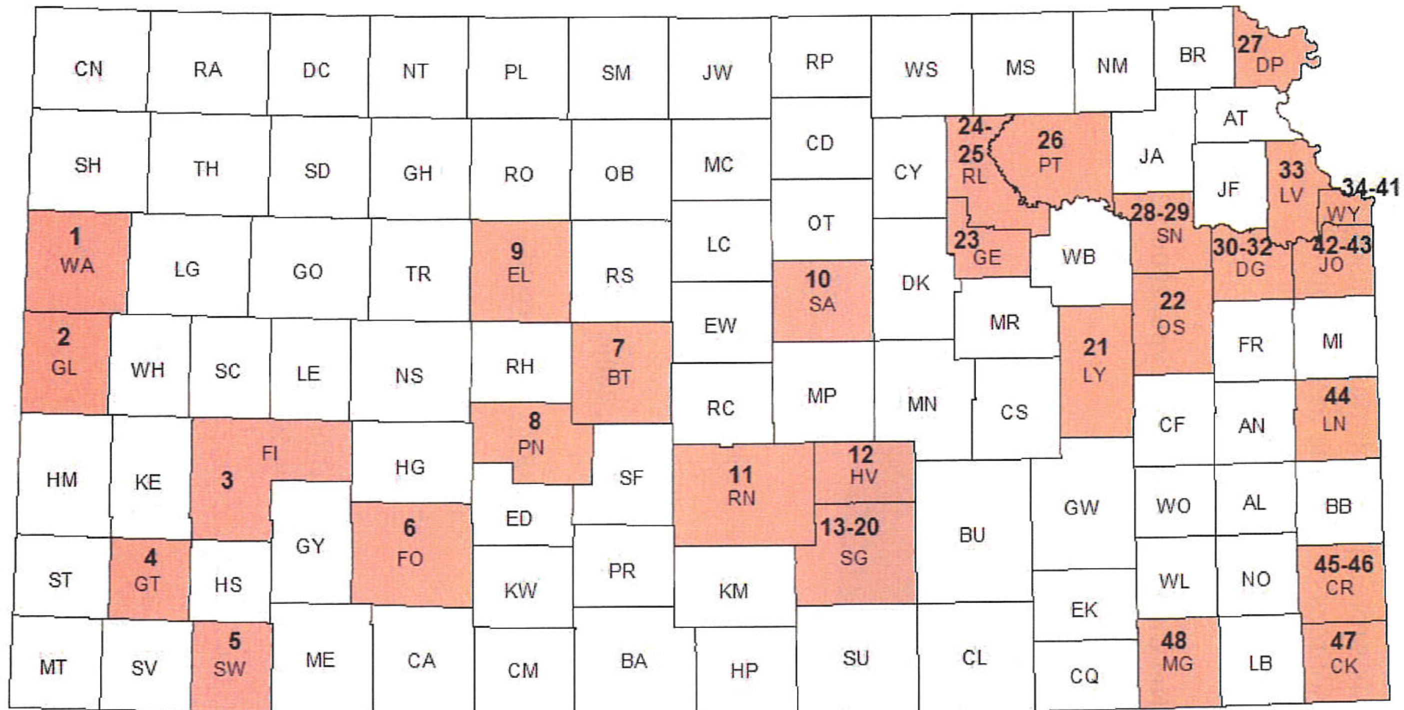
Sixty percent of the revenues of safety net clinics do *not* vary with patient volume. As the number of patients served in the clinics increases, it will be necessary to expand non-patient sources of revenue to stay solvent.



Safety Net Clinic Revenues, by Type, 2006

	Revenue	Percent
State Grant(s)	$4,268,648	12.0%
Federal CHC Grant	$6,940,788	19.6%
Private Foundation Grants	$3,821,476	10.8%
Net Patient Revenue	$13,821,773	38.9%
Other	$6,641,905	18.7%
TOTAL	$35,494,590	100.0%

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

Kathleen Sebelius, Governor
Roderick L. Bremby, Secretary

DEPARTMENT OF HEALTH
AND ENVIRONMENT

www.kdheks.gov

Division of Health

Testimony on Senate Bill 697
Presented to
Senate Committee on Public Health and Welfare

By

Chris Tilden
Director, Office of Local and Rural Health

April 3, 2008

Chairman Barnett and members of the Committee, my name is Chris Tilden and I am the director of the Office of Local and Rural Health at KDHE. As you know, Local and Rural Health is privileged to manage the primary care clinic grant program. Primary care clinics serve as a safety net and "medical home" for many of the uninsured residents of the state of Kansas, and for other low-income or underserved individuals, including those covered by Medicaid and HealthWave who cannot find a private provider in their area. While state-funded primary care clinics vary widely in terms of mission, services, and strategic approaches to meeting community needs, they all strive to provide the patient-centered care and individual health care planning that is essential to the "medical home" concept.

Currently the primary care clinic grant program provides \$5.2 million annually to 31 clinic sites in the state, and philanthropic support provides another \$2.5 million for dental hubs (also supported through the state program). In calendar year (CY) 2007 state-funded clinics provided care to 150,105 individual patients, including approximately 80,000 patients with no health insurance. If you accept current estimates that approximately 300,000 Kansans do not have health insurance coverage, the state-funded clinics are now serving over 25% of the uninsured in the state.

These numbers clearly point to the value of the network of safety net clinics in the state. I would like to publically commend the clinics and their partners, including both community partners and those at the state level like the Kansas Association for the Medically Underserved, for the important services they provide every day to thousands of Kansans. At the same time, however, the data also indicate substantial unmet need exists in the state.

OFFICE OF LOCAL AND RURAL HEALTH
CURTIS STATE OFFICE BUILDING, 1000 SW JACKSON ST., S[illegible]
Voice 785-296-1200 Fax 785-29[illegible]

PUBLIC HEALTH AND WELFARE
DATE: 04/03/08
ATTACHMENT: 2

We recognize that state funding of the primary care clinic program is but one facet of a statewide approach to health care access that also includes health insurance expansion and other reforms. However, clinics historically have shown the ability to respond to community need, and to opportunities created by enhanced funding levels, with increased capacity to serve larger patient populations. There are a number of reasons to expect the clinics are well situated to once again respond to this opportunity to increase safety net capacity:

1) All of the currently-funded clinics have applied again for funding this year, and many proposals will seek funding to increase the number of patients served.
2) An additional five clinics that have not previously sought state funding have applied this year in order to expand their operations, and two applicants in northwest Kansas are looking to establish new clinics in areas that currently are not served by a safety net site.
3) The most recent data on clinic productivity shows that 20,000 more patients, (8,000 of whom were uninsured) were seen by state-funded clinics in Calendar Year 2007 than in 2006, demonstrating clinics' capacity to expand operations to meet increased demand (see accompanying table).

Given a strong track record of performance among the state-funded primary care clinics, the knowledge that existing sites are already planning for growth which will be reflected in increased requests for funding from KDHE, and new funding requests from seven sites, we believe additional primary care clinic funding is warranted as part of an overall strategy to help provide more primary care to uninsured Kansans. Our existing primary care staff are positioned to administer this additional responsibility without additional resources should more funding be allocated to the program.

Thank you for the opportunity to appear today. I will be happy to respond to any questions you may have about the primary care clinic program.

Increase in Patient Volume

Primary Care Clinic Program 2006-2007 (Calendar Year)

Clinic Setting	Patients Seen (new)	Uninsured Seen (new)	State Funding (increased/new funding for FY 2008)
Existing Sites	14,052	3,175	$1,205,900
New Sites	6,255	4,724	$744,100
TOTAL	**20,307**	**7,899**	**$1,950,000**

att 3

KHPA Testimony on Safety Nets to the Senate Public Health and Welfare Committee

April 3, 2008

Marcia Nielsen, PhD, MPH
Executive Director
Kansas Health Policy Authority

1

Importance of Safety Nets

- Safety nets serve uninsured and low-income Kansans across the state.
- Safety nets provide access to primary care, preventive services, and medical homes for populations who otherwise would have no access to these health care services.
- Until Kansas can provide health insurance to the 300,000 uninsured, safety nets will remain a critical part of the health care system in Kansas.

2

KHPA

The Uninsured

Total Uninsured in Kansas: 10.5%

9.4%
9.9%
6.7%
16.4%
5.4%
9.3%
10.9%
16.8%
12.8%
11.5%

Source: Kansas Health Insurance Study, 2001. Kansas Insurance Dept.

KHPA

Lower Income = More Uninsured

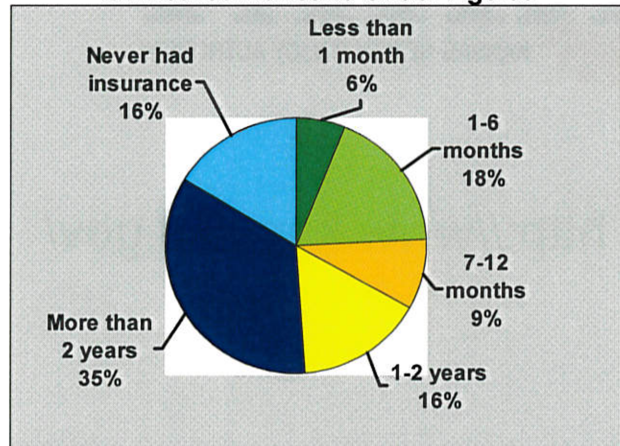
Uninsured Kansans under Age 65 by Income and Distribution of Uninsured

Percent
95,000
31.5%
25.3%
43,000
15.1%
107,000
10.7%
4.2%
100% or Less
101% to 150%
151% to 200%
201% to 250%
251% or Greater
Federal Poverty Level (FPL)

Source: Kansas Health Insurance Study, 2001. Kansas Insurance Dept.

Most Kansans Uninsured for More Than A Year

Length of Time Without Health Coverage: Uninsured Kansans Under Age 65



Source: Kansas Health Insurance Study, 2001. Kansas Insurance Dept.

KHPA Reforms Positively Impacting Safety Net Clinics

- **Personal Responsibility**
  - Promote Health Literacy
- **Medical Homes:**
  - Define medical homes in statute
  - Implement statewide Community Health Records
  - Promote insurance card standardization to include Medicaid ID cards
  - Increase Medicaid provider reimbursement rates
- **Health Prevention:**
  - Provide dental care for Pregnant women in Medicaid
  - Improve tobacco cessation within Medicaid
  - Expand cancer screenings

http://www.khpa.ks.gov/

Written Testimony of
Senate Bill 697
Senate Ways and Means Committee

Submitted by
Amy Falk
Executive Director
Caritas Clinics, Inc.
(Duchesne Clinic in Wyandotte County
Saint Vincent Clinic in Leavenworth County)

As the director of two safety net primary health care clinics, I am pleased to offer my support for Senate Bill 697, a bill that would increase funding to the safety net clinics such as Caritas Clinics, Inc.

Caritas Clinics, Inc. is comprised of Duchesne Clinic in Wyandotte County, Kansas and Saint Vincent Clinic in Leavenworth County, Kansas. The clinics provide primary health care services to those individuals who have no form of medical insurance including Medicare and Medicaid or private insurance. Individuals receiving care at the clinics must live at or below 150 percent of the Federal Poverty Guidelines.

Having provided over 200,000 patient visits since their inception, Caritas Clinics seek to improve the health of the community, one patient at a time, and to provide primary medical care that helps patients become prevention oriented rather than disease oriented. Clinic patients are seen on-site by mid-level (i.e. physicians' assistants or nurse practitioners) staff providers or by one of more than 50 volunteer physicians.

During our last fiscal year, the clinics provided over 15,000 patient visits to approximately 2,000 Kansans without healthcare of any kind. Each year, we are seeing an increase in clinic usage. We are seeing more and more patients seeking care at our clinics for the first time and in sometimes, needing assistance of any kind for the first time in their lives. In the first nine months of our current fiscal year, we have seen over 500 brand new patients. There are significant costs associated with the increased access to care that the clinics are providing. These include but are not limited to having to increase the number of staff, an increase in the supplies needed to provide care and an increase in the medications needed by patients.

Additionally, patients seeking care at the clinics are much more complex, which in turn also has increased costs. Examples include:

Recently, the clinic began to take care of a patient whose father is a patient at the clinic. The 20-year old patient was a victim of multiple gun shot wounds to his chest and abdomen. He was seen in the emergency room at a local hospital where he had emergency surgery. Although the gunshot wounds did not affect his spine directly, he suffered from temporary paralysis. The bullets went through his colon and bladder. He has not regained full use of lower extremities and uses a walker. A volunteer physical therapist has worked with him at the clinic. He continues to be seen at the clinic for pain management, colostomy management, and to get medications and supplies to treat skin irritation. When he had the colostomy he was told it was reversible. We are working with WyJoCare, a specialist referral program, to try to get him to surgery.

On a routine visit for a 50-year old female patient, one of our nurse practitioners detected a heart murmur, and referred the patient to our volunteer cardiologist. After a procedure at the CATH lab at Providence

Medical Center, it was determined that she had a congenital displacement of coronary arteries. Her condition was a rare one. The patient was anxious and depressed. Surgery was scheduled. Post surgery she continues to be monitored at the clinic. Services provided to both the patient and the patient's family are counseling related to the patient's depression and anxiety, both pre and post surgery, pain management, and providing and managing her complex medications.

Increased funding, would allow us to hire additional staff to see patients, in addition to helping to purchase the additional medical supplies and medications needed to treat patients. Specifically, we would like to hire a full-time physician to serve as our medical director. Currently, we operate with two wonderful volunteers operating in that position. As the patient load has increased and the complexity of patients, this position truly needs to be a paid staff position.

On behalf of our patients and those individuals within our communities that do not have access to healthcare, I ask for your favorable consideration of this bill.

Senate Bill 697

Sally Tesluk
Executive Director
PrairieStar Health Center

Mr. Chairman, members of the Committee, I am Sally Tesluk, Executive Director of PrairieStar Health Center (PSHC), in Hutchinson. PrairieStar has been a Federally Qualified Health Center (FQHC) since July of 2007, and provides a full range of services: medical and dental care, one-on-one patient focused education, prescription assistance program through the pharmaceutical companies, minor emergency and surgical services; essentially any services that would be available to you at your own physician's office.

In 2007, our providers saw 5074 distinct patients and provided 12,278 medical encounters. This is an increase of 27% distinct users and 12% encounters from 2006. In 2008, we project an increase of 19% users and a 41% increase in encounters. And these statistics only address the medical side of our operation. The for-profit clinics in Hutchinson will not see uninsured patients unless they bring payment in full at the time of service. If they or any member of their families have declared medical bankruptcy, neither clinic will see them, even if they are able to obtain insurance. Without PSHC, these patients have no medical recourse but the hospital emergency room. In addition, many out-of-county residents have come to PSHC in search of care. We do not want to turn any individual in need away from the clinic, but we need more money to accommodate them.

I am writing today to ask you to vote in favor of Senate Bill 697. The increase in funding is urgently needed so that we can serve the 19,893 individuals in Reno County with incomes below 200% of the Federal Poverty Guidelines (according to the last U.S. Census).

Since PSHC's inception, we have received a KDHE Primary Care grant each year. This grant has been incredibly helpful because it is the only grant we receive that allows us to use the monies for operational expenses. There are always grants available that will help an organization with start-up costs for a new service, but will not commit to aid in program sustainability. Start-up grants are not practical because they introduce a new service the health center is then expected to continue. Centers like PSHC need funds to help with the every day, non-glamorous expenses. That is why the monies from KDHE are so vital to health centers.

KDHE funds have helped PSHC initiate and build a huge prescription drug program. In 2007, using retail prices, PSHC procured 2.1 million dollars worth of medications for our patients. We also depend on state funds to help with staff salaries, as well. As we care for more patients, we must hire more staff, including the most expensive, providers. Monies to help underwrite this cost are vital to our continued viability.

Since moving into our new facility and becoming an FQHC, PrairieStar's expenses have risen exponentially. Employee benefits have increased 51%. Rent for our new, much larger facility is up 753% from 2006. Since we added several new staffers to keep up with the need, the costs of providers and additional supplies have also skyrocketed. Administrative expenses are up 1,443% due to these and a myriad of other items for daily use. Those are just a few examples of how much more expensive it has become to care for our ever increasing patient load.

We really need funds to help us sustain our new dental program. Additional monies would help us offset the cost of dental salaries. In 2007, which was only a partial year for our dental program, we had 1151 distinct users who generated 2249 encounters. We project an additional 1,329 users who will generate an additional 3,961 encounters in the next grant year. Demand for dental services is so large, PSHC cannot keep up with the need. Dental supplies are approximately two times more expensive than medical, which is another area where we would use additional grant funds. The above examples only take into account dental needs. As I explained in the second paragraph of this testimony, medical expenses have also increase dramatically.

Please allow me to provide you with an example of how PrairieStar has helped just one individual. This gentleman came to us for his annual Department of Transportation physical. He was employed full time as a distance truck driver. The exam revealed uncontrolled Type 2 Diabetes, which, due to regulations, resulted in his losing his job. He was in his fifties, with no income or condition which would allow him eligibility for Medicaid. Financially he was in such a dire position, he was attempting to decide whether to purchase his diabetic medications, food or pay his rent. Citizens should not be confronted with such untenable options!

Because PrairieStar receives a KDHE Primary Care grant, we have an extensive pharmacy assistance program. Our staffers were able to procure his $1,300 monthly medications for $65.00 for three months worth; a savings of $3, 835 each month. When his diabetes comes under control, he will be able to return to his job. Needless to say, he was incredibly grateful for the help. Help we could provide because the Kansas Legislature cares for its citizens, and demonstrates so by providing clinics the funding for Kansans in need.

This Legislature and this Committee in particular has been very supportive of the safety net clinics in recent years. We are very grateful for this support. Thank you. In order to continue the progress we have made together, I, once again, urge you to vote in favor of SB 697.

Senate Bill 697
Senate Ways and Means Committee

Marcie Strine, Interim Executive Director
United Methodist Mexican-American Ministries, Inc.

Thank you so very much for the support you have provided for Safety Net Clinics in past years. United Methodist Mexican-American Ministries (MAM) has been providing social, educational, and spiritual services for people of all races, colors, and faiths in Southwest Kansas since 1974 and has provided medical services since 1987. Full-time medical clinics are located in Garden City, Dodge City, and Liberal. A part-time medical clinic is located in Ulysses. In late 2007 MAM was able to begin providing dental services, to funds appropriated by the Kansas Legislature and private foundations.

In 2007, 6,173 unduplicated clinic patients from 102 zip code addresses had 25,833 primary care encounters and 34,862 total encounters through the MAM clinics. This includes 3,247 more medical encounters than 2006 and 4,503 more encounters than 2005. About 74% of MAM patients have no means of third party pay. Only 12% are privately insured and 13% have Medicaid. Ninety-one percent (91%) of clients have household incomes below 200% of the federal poverty line, although almost all age-appropriate clients are employed.

MAM partners with the State of Kansas in a number of efforts besides primary care. The Immunization Action Plan, which receives $ 32,000, provided 7,105 immunizations and TB tests for 3,318 unduplicated clients, mainly children under age 18. These figures are NOT included in the totals above. MAM provides also partners in providing services through Early Detection Works, Farmworker Case Management, Diabetes Education, and HIV/AIDS Outreach and Case Management. These programs are vital to the health and well-being of people in western Kansas and the money spent on prevention saves lives plus money spent on care.

MAM has and will continue to provide the highest quality care, health education, preventive, and outreach services at the lowest possible cost. Primary care funds helped MAM increase its physician staff from 1 FTE to 2.55 FTE. But costs – especially for medical, dental, and pharmaceutical personnel – continue to rise. Increased funding is essential in maintaining current caseload numbers as well as adding new patients.

State funding for primary care is instrumental in attracting federal, local, and private funds. MAM was able to become a Federally Qualified Health Center because the State of Kansas was already an investor in MAM primary care. United Ways, Avon Breast Health Foundation, Susan G. Komen Foundation, Soroptimist International, United Methodist Health Ministry Fund, Western Kansas Community Foundation, Sunflower Foundation, Kansas Health Foundation, Delta Dental Foundation and others MAM services in part because state primary care funds help maintain clinic stability. In fact, each state primary care dollar to MAM leverages at least twelve additional dollars.

Investment in primary care is cost-effective for Kansas and reaps abundant health benefits for Kansans. Please, add $1.4 million dollars for Primary Care Grants through KDHE and $100,000 to KAMU for technical assistance.