MINUTES

JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT

December 17, 2009
Room 143-N—Statehouse

Members Present

Senator Jim Barnett, Chairperson
Representative Brenda Landwehr, Vice-chairperson
Senator Jeff Colyer
Senator David Haley
Senator Laura Kelly
Senator Roger Reitz
Senator Vicki Schmidt
Representative Bob Bethell
Representative Don Hill
Representative Peggy Mast
Representative Louis Ruiz
Representative Jim Ward

Staff Present

Terri Weber, Kansas Legislative Research Department
Melissa Calderwood, Kansas Legislative Research Department
Amy Deckard, Kansas Legislative Research Department
Nobuko Folmsbee, Office of the Revisor of Statutes
Doug Taylor, Office of the Revisor of Statutes
Ken Wilke, Office of the Revisor of Statutes
Jan Lunn, Committee Secretary

Conferees

Dr. Andy Allison, Acting Executive Director, Kansas Health Policy Authority
Doug Farmer, Deputy Director, Kansas Health Policy Authority
Laura Howard, Deputy Secretary, Kansas Department of Social and Rehabilitation Services
Roderick L. Bremby, Secretary, Kansas Department of Health and Environment
Martin Kennedy, Acting Secretary, Kansas Department on Aging
Aaron Dunkel, Deputy Secretary, Kansas Department of Health and Environment
Dr. Helen Connors, Chairperson, e-Health Advisory Council
Larry Pitman, Chief Executive Officer, Kansas Foundation for Medical Care

Others Attending

See attached list.

Morning Session

Chairperson Barnett called the meeting to order at 9:30 a.m. and welcomed those attending.

Update on Kansas Health Policy Authority (KHPA) Operations and Strategic Plan

Doug Farmer, Deputy Director and Director of the State Employee Health Plan, Kansas Health Policy Authority (KHPA), was recognized to provide testimony on behalf of Dr. Andy Allison, Acting Executive Director, who had laryngitis. Mr. Farmer introduced Mr. Ken Daniels, KHPA board member. Mr. Farmer began his testimony (Attachment 1) by highlighting key points including KHPA's new focus, KHPA's budget summary, and agency "next steps." The new focus is required due to changing circumstances related to the economy, new state leadership, and a new federal administration that is quickly advancing national health care reform. Mr. Farmer discussed with Committee members the necessity of soliciting feedback from policymakers, the refocus of resources on core program operations, the task of repositioning the State for national health care reform, and the securement of federal American Recovery and Reinvestment Act (ARRA) funding for health information technology (HIT) and health information exchange (HIE). To accomplish these goals, a revised four-year strategic plan was approved by the KHPA Board in November 2009. The strategic plan includes the agency's new priorities, performance targets, the focus on advancing a medical home, core agency operations, cost management, and alignment of individual roles with organizational activities and goals. Mr. Farmer provided an update on recent achievements that included the securing of a $40 million grant to replace the State's Medicaid enrollment system and the expansion of health insurance coverage to children below 250 percent of the 2008 federal poverty level (FPL). A summary of the Kansas Access to Comprehensive Health (KATCH) project was distributed which described the grant and its goal of enrolling uninsured individuals in public health programs including the technology to accomplish this (Attachment 2).

KHPA—Impact of Governor's November Allotments

Mr. Farmer provided an account of the impact of recent budget reductions for FY 2009 and FY 2010. Discussion followed on the impact of the Governor's November 2009 allotment for KHPA operations; specifically, on the elimination of extra contract funding for the eligibility Clearinghouse, the reduction in staff overtime dedicated to the Clearinghouse eligibility backlog, the elimination of the Call Center for Medicaid providers and the reduction of Call Center capacity for Medicaid beneficiaries.

Concerning the elimination of Call Center funding, which was projected to save the agency approximately $250,000 SGF, Senator Schmidt asked how much the fiscal agent was paid to process each claim received in the Call Center. Mr. Farmer responded the cost was 76 cents per transaction. Senator Schmidt expressed concern that with the elimination of Call Center support, more claims would be filed, thereby resulting in higher long-term costs. She provided the example of a provider who files a claim (without the assistance of Call Center support); the claim is denied; and the provider files a second, and possibly a third or fourth claim. Senator Schmidt stated that

without the assistance of a liaison to the provider, more funds will be spent in claims filing, thereby causing delays in provider payments. She further stated that critical access hospitals may close because of funding decreases and delays, and caseload costs will increase due to decreased claim accuracy. Senator Schmidt encouraged an immediate reassessment of the decision to eliminate the Call Center services.

With respect to the Governor's across-the-board 10 percent reduction in Medicaid provider rates included in the November allotment, Senator Schmidt questioned the impact on pharmacies' reimbursement based upon federal upper limits for drugs in the Medicaid program. Mr. Farmer responded that it is his understanding that the 10 percent cut would apply only to the dispensing fee; the product claim would remain untouched by the reduction. Senator Schmidt pointed out such reductions in Medicaid provider rates subsequently reduce federal matching funds. In her role as a registered pharmacist, Senator Schmidt reported there is an opportunity for significant cost savings with the improved management of Schedule II through Schedule V narcotic drugs prescribed to Medicaid recipients. She questioned why other cost-savings strategies such as this had not been evaluated by KHPA instead of cutting funding that results in lost federal funding matches. Mr. Farmer stated a written response would be distributed at a later time.

Senator Schmidt inquired as to why federal government drug rebates to the State are deposited in the State General Fund rather than in the Pharmacy Fund or other public health medical funds. Mr. Farmer indicated a written response would be forwarded to Senator Schmidt and other Committee members.

Mr. Farmer reported that one of the reduction options included in the agency's FY 2011 budget submission was to align all professional rates in Medicaid to 86 percent of the average Medicare rate for similar groups of services. Senator Schmidt asked to what extent that percentage would be affected by the Governor's across-the-board 10 percent reduction. Mr. Farmer indicated the 86 percent would not be affected that dramatically; however, a written reduction estimate would be provided to the Committee.

Representative Mast noted that KHPA reductions in customer and support services could impact the State's ability to comply with federal requirements for timely claims processing. She asked what plan is in place to address any federally imposed penalties. In addition, with increased Medicaid applications for services, she asked if there is a cost estimate for funding matching dollars required by the federal government. Mr. Farmer indicated he would provide the agency's estimated cost for funding Medicaid recipients in a written response to Committee members. Also, he reported that communication has occurred with the Centers for Medicare and Medicaid Services (CMS) requesting input on the KHPA recommendation. Representative Mast also asked whether the Inspector General position would be filled in the near future. Dr. Allison responded that the Board had offered the position to Mr. Nick Cramer, and that he would be officed in the Mills Building. He will serve as Acting Inspector General until confirmation by the Senate.

Representative Bethell reiterated Senator Schmidt's concern related to cost reductions that eliminate federal matching funds. He asked if the purpose of reducing Medicaid costs was to curtail Medicaid growth, or to force evaluation of revenue enhancements. Mr. Farmer responded that the agency was unaware of an intentional decision to cut operational Medicaid costs for the purpose of slowing growth and the use of services. Representative Bethell also expressed concern regarding the possibility of becoming non-compliant with federal requirements for matching funds and for ARRA funding. Representative Bethell asked Mr. Farmer to furnish the percentage of Medicaid usage in Kansas compared to the national percent. Mr. Farmer stated that the information would be provided to the Committee at a later date.

Senator Colyer asked what alternatives, other than the 10 percent Medicaid cut, were discussed. Mr. Farmer indicated there was nothing close to the scale of the approved recommendation. Senator Colyer questioned whether consideration was given to out-of-state service rates for the Medicaid program, which has resulted in significant savings for some states. Mr. Farmer indicated that the out-of-state rates issue had been examined, and that he would discuss this with Senator Colyer.

Considerable discussion from Committee members followed regarding KHPA's effort to ensure on-going analyses for cost reductions and cost savings, the lack of alternatives presented for evaluation, and the potential for federal penalties with implementation of the recommendations provided in testimony.

Senator Kelly echoed concerns of eliminating the Call Center support services, particularly in light of a recessive economy which forces more Kansans to apply for assistance as well as the depth of reductions already taken. She encouraged restoration of funding for Call Center support services. Senator Kelly also requested additional information concerning the $250,000 projected savings, in particular, whether the savings was for a full year.

Department of Social and Rehabilitation Services (SRS)—Impact of Governor's November Allotments

Laura Howard, SRS Deputy Secretary, was recognized to discuss the impact of the Governor's November Allotments (Attachment 3). Ms. Howard presented information regarding the details of the FY 2010 budget reductions included in the 2009 allotments. She discussed various programs impacted by the reduction. Included in the reductions are various grants that are expected to affect community mental health centers, developmental disability assistance, and General Assistance. In an attempt to lessen the effect of the reductions, SRS implemented a staffing plan that included a hiring freeze and organizational restructuring. Ms. Howard discussed the categories of services that are tied to federal programs and funding that includes mandatory requirements. Ms. Howard indicated that further reductions of the state hospital budgets would necessitate ceasing voluntary admissions at State mental health hospitals and possibly closing patient units. The Governor's November allotments will cause policy changes, including limiting personal care assistant hours; eliminating dental care for the Developmental Disability (DD) Waiver, Physical Disability (PD) Waiver, and Traumatic Brain Injury (TBI) Waiver; and eliminating emergency respite care for the DD Waiver. Ms. Howard reported that if additional reductions are required, the elimination of total programs would be evaluated to attain further savings.

Following discussion regarding Ms. Howard's testimony, Chairperson Barnett asked about the provisions and restrictions for beneficiaries using a Kansas Vision Card (SRS Food Assistance Program) and whether there were programs for monitoring fraud or abuse of the program. Ms. Howard stated that additional information would be provided to Committee members.

Kansas Department of Health and Environment (KDHE)—Impact of Governor's November Allotments

Secretary Roderick Bremby distributed copies of his testimony (Attachment 4) and discussed the effects of budget reductions for FY 2010, which included:

- A hiring freeze;

- The abolishment of vacant positions;
- The elimination of oral health educational activities for the Maternal and Child Health Program;
- An overall reduction in Environmental Laboratory services;
- A decrease in the contract for the Kansas Association of the Medically Underserved (KAMU) which will impact the State's Primary Health Program;
- Elimination of funding for the Teen Pregnancy Case Management Program and the methamphetamine clean up program; and
- A funding reduction to the Infant Toddler Program, the Coordinated School Health Program, vaccine purchases, and the State Water Plan expenditures.

Kansas Department on Aging (KDOA)— Impact of Governor's November Allotments

Acting Secretary Martin Kennedy discussed the impact of the Governor's November allotments and adjustments to the FY 2010 and FY 2011 budgets (Attachment 5). FY 2010 budget adjustments included reductions to the Senior Care Act funding; Medicaid reimbursements were reduced along with the corresponding loss of federal matching funds; the Home and Community Based Services (HCBS) Frail Elderly (FE) Waiver was held at the 2009 level; nursing home rates were held flat; and the Area Agencies on Aging (AAA) core funding was suspended. Secretary Kennedy reported that scrutiny of programs continues on a month-by-month basis and operating costs will continue to be constrained for FY 2011. Mr. Kennedy noted that the impact of these reductions may cause layoffs in nursing homes, may restrict or eliminate Medicaid admissions to nursing homes, and may negatively impact quality of care in nursing facilities for the mentally ill. Secretary Kennedy reported that all available Medicaid spaces for the Program of All-Inclusive Care for the Elderly (PACE) currently are filled.

Afternoon Session

Senator Barnett requested that Committee members review the minutes of the June 12, 2009, meeting (previously distributed to Committee members). *Upon a motion by Representative Landwehr and a second by Representative Ruiz to accept the minutes of the June 12, 2009, meeting as submitted. The motion passed.*

Update on Statewide Health Information Technology and Health Information Exchange Initiative

Secretary Roderick Bremby provided information on the progress of the Statewide Health Information Technology and Health Information Exchange (HIE/HIT) initiative (Attachment 6). (Note - because of a scheduling conflict, Secretary Bremby's presentation on the HIT/HIE Project was presented in the morning session). Secretary Bremby reported that KDHE is the state designee for the HIT/HIE project oversight. In this role, KDHE is accountable to facilitate the creation of strategic

and operational plans for a HIE infrastructure. Discussion was heard related to funding from federal grants and federal stimulus dollars by the inclusion of the Health Information for Economic and Clinical Health Act (HITECH) in ARRA. Secretary Bremby stated that, although there will be an initial infusion of stimulus dollars for implementation, on-going expenses will occur and must be addressed to ensure the implemented model is sustainable. Information on the e-Health Advisory Council (eHAC), its structure and membership, its five domain workgroups and chairpersons of the workgroups, and other partners and stakeholders involved in the project were discussed.

Dr. Helen Connors, professor at the University of Kansas School of Nursing and Executive Director for the University of Kansas Center for Health Informatics, was introduced. Dr. Connors chairs the eHAC which was established to guide the continued development of Kansas E-Health initiatives based on the final recommendations of the Health Information Technology/Health Information Exchange Policy Initiative, the Kansas Health Information Exchange Commission, and the Health Information Security and Privacy Collaborative (HISPC). Dr. Connors presented testimony related to the Advisory Council's five domain work groups and their chairpersons; the structure and purpose of the domain work groups; and an organizational chart outlining the state's HIT governance structure, including the HIT (Attachment 7).

Dr. Connors also described the work of the eHAC since August 2009. Proposals submitted include expanding the Chronic Disease Electronic Management System with a grant request of $2.8 million; a funding request for $4.3 million to provide essential workforce training through seven community colleges, as well as Kansas State University and the University of Kansas; a funding request for $9 million for the creation of a Regional Health Information Technology Center (RC) for the state; and a funding request for $10 million to develop the infrastructure to achieve a widespread and sustainable health information exchange within and among states through the meaningful use of certified electronic health records (EHR). All funding request notifications will occur in the next several months. Dr. Connors discussed the challenges involved in the project, such as implementation of broadband in rural areas, long-term sustainability, and statutory or policy revisions within federal and state law.

Questions from Committee members included whether legislation related to this project is anticipated in 2010; how the exchange of medical information is accomplished; who owns the medical record; whether information contained in the patient's secure record could be used for public health initiatives; and whether various operational models (public, private, public/private) are being evaluated, particularly where other states have implemented similar plans.

Dr. Connors reported that Jeff Ellis, Chairperson of the Legal Policy Workgroup, has engaged the voluntary services of 26 healthcare attorneys from across the country to review the package being recommended by the Legal Policy Workgroup. The draft will be submitted to the KDHE Secretary, eHAC, and subsequently to the Legislature with a request for statutory changes in 2010. Dr. Connors explained that to transmit and receive records, all parties must have an electronic health system. The transfer of medical information is exchanged via a master patient index with a patient locator system to transfer the record as needed. She explained that typically, the owner of the record is the patient's primary care physician using a medical home concept. Dr. Connors noted that the Legal Policy Workgroup has focused on privacy and security requirements for system development and use. At the current time, it is hoped that the electronic health record (EHR) will be interactive, which would allow the patient to access diagnostic test results and to enter information related to the patient's health condition and self-care management. In addition, data points within the EHR could be used for public health initiatives. Dr. Connors assured Committee members that the various operational models are being evaluated by the workgroups.

Senator Barnett expressed concern that with reductions in Medicaid reimbursement, a fragile healthcare system with limited providers is being created which could jeopardize "the medical home" as it currently is defined.

Larry Pittman, President and CEO, Kansas Foundation for Medical Care (KFMC), discussed his involvement in the project. Since KFMC's purpose is to facilitate the improvement of healthcare in Kansas, that entity was invited to submit a proposal to the Office of the National Coordinator (ONC) for Health Information Technology to serve as the Regional Extension Center for Kansas. If awarded, KFMC will provide expert technical support (subsidized by federal funds) to over 1,200 primary care providers who are interested in adopting EHRs or using existing systems to achieve "meaningful use" incentives (Attachment 8). Mr. Pittman reported incentives up to $44,000 per Medicare provider over five years and up to $63,750 per Medicaid provider over six years are possible. Incentives must meet "meaningful use" definition, exchange health information, and providers must report on quality measures. Family practice, OB/GYN, internal medicine, and pediatrics practitioners are eligible for incentives as well as community and rural health centers serving under- and uninsured Kansans. Mr. Pittman also reported on the project's scope and its short- and long-term program goals. Committee members discussed the EHR and how to ensure a standard e-health system purchased by providers is capable of information exchange. Mr. Pittman reported that any system that is approved by the Certification Commission for Healthcare Information Technology (CCHIT), the United States certification authority for EHR and their networks, guarantees the system's capability for health information exchange.

Annual Review of the State Children's Health Insurance Plan (SCHIP)

Barbara Langner, PhD, Acting Medicaid Director, KHPA, presented information related to managed care contractors who provide Medicaid and SCHIP services to 173,462 HealthWave members (Attachment 9). (The Medicaid managed care program and SCHIP have been combined into one program called HealthWave.) Features of the Plan were reviewed as well as outcomes, measurement benchmarks, and patient satisfaction surveys. Requirements for data collection were reviewed, and identified improvement areas were presented. Plan expenditures and rates were discussed. Dr. Langner indicated that in FY 2010, goals include creating new coverage options in western Kansas, adjusting Mental Health benefits for SCHIP members, ensuring a smooth process for SCHIP expansion, monitoring performance improvements, and assessing the net impact of managed care organizations on State expenditures.

Committee members discussed the request by the KHPA Board to analyze the effect of consolidating HealthWave claims payment and care management into the Medicaid fee-for-service operation. In addition, considerable discussion was heard regarding the federal mandate that requires citizenship and identity verification for all SCHIP applicants and the challenges this adds to the Clearinghouse difficulties and delays.

Chairperson Barnett requested data related to the immunization rates for children in HealthWave compared to those in commercial plans and the cost for HealthWave children compared to private insurance plans. Dr. Langner stated that information would be provided to Senator Barnett and the other Committee members.

Recommendations for the Committee Report to the 2010 Legislature

Committee members recommended that the following items be included in the Committee Report to the 2010 Legislature:

- That the Kansas Health Policy Authority restore total funding for the Call Center support services because of the potential that elimination of support services could result in the submission of multiple claims for one visit from each provider, could create claim inaccuracies, could delay provider reimbursement payments, could negatively impact quality of care, and could cause hospitals to close or providers to eliminate caring for the Medicaid population;

- That the Kansas Health Policy Authority evaluate and provide information to the 2010 Legislature on other alternatives for budget reductions, including improved program efficiencies or reduction of fraud and abuse, such as narcotic prescription drug abuse by Medicaid beneficiaries;

- That the Kansas Health Policy Authority include in the evaluation of its budget reduction recommendations for the amount of lost federal match funding which could result in an increase in State long-term health expenditures and health care access issues;

- That SRS provide additional information to the Committee and the 2010 Legislature regarding the Kansas Vision Card, particularly the quality of food purchased with these funds and how the program is monitored for fraud and abuse; and

- That all members of eHAC, the HIT/HIE domain workgroups, the chairpersons of these groups, and others who have volunteered and dedicated their time and skills to the Statewide Health Information Technology and Health Information Exchange Initiative be publicly acknowledged, applauded, and thanked by the Joint Committee on Health Policy Oversight. The Committee believes that the magnitude of this project will have far-reaching effects on the future of health care in Kansas.

Chairperson Barnett thanked the Committee, staff, and conferees for their support, ideas, and input. The meeting was adjourned at 3:10 p.m.

Prepared by Jan Lunn
Edited by Terri Weber

Approved by Committee on:

March 26, 2010
(Date)

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JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT

December 17, 2009

Sign In

Name	Organization
Linda Steinke	
Dyllis Klein	
John Kiefhaber	Ks. Chiropractic Assoc.
Jeff Bottenberg	KU Hospital Auth
Chad Moore	Children's Mercy Family Health Partners
Nancy Zogleman	Polsinelli
John Moore	Topeka
Brian Witt	Via Christi
[illegible]	United Health Group
Sean Miller	Capitol Strategies
Jon Peterson	Capitol Strategies
Ken Daniel	TIBA
Dodie Wellshear	Ks Academy of Family Physicians
Gina Maree	KHI
Barb Conant	KDOA
Tom Bruno	HP Enterprise Services
[illegible]	Kennedy & Assoc.
Chad Austin	KHA
David Rowe	KU Medical Center
Helen Connors	BUMC

Update from the Kansas Health Policy Authority

Testimony before the Joint Committee on Health Policy Oversight

December 17, 2009

Dr. Andrew Allison, KHPA Acting Executive Director

1

Overview

- **KHPA's New Focus**
  - Changing circumstances
  - New strategic plan
  - Recent achievements
- **KHPA Budget Summary**
  - Reductions approved by 2009 Legislature
  - FY 2011 Budget Recommendations
  - FY 2010 Governor's Allotments
- **Next Steps for the Agency**

2

KHPA's New Focus

Summary of 2009 Annual Board Retreat and Subsequent Direction

3

Circumstances differ dramatically from those facing KHPA at its inception in 2006

- **New economy**
  - Immediate reductions in funding for KHPA operations
  - Reductions possible (now realized) in operations and services in FY 2010
  - Large structural deficit that grows substantially with expiration of Federal stimulus dollars in 2011
- **New state leaders**
  - Transition in KHPA leadership
  - Transition in statehouse since KHPA's founding
- **New federal administration**
  - New President focused on quickly advancing major health care reforms
  - Former Governor Sebelius in position of national leadership
  - Reform options address several of KHPA's health policy agenda items

4

Solicit Feedback from Policymakers

- **Build relationships following political and agency transitions**
- **Make clear KHPA's intention to support state's imperative to balance the FY 2010 and 2011 budgets**
  - KHPA recognizes the magnitude of the state's budget gap and the significant share of state spending attributable to the Medicaid program
  - KHPA understands the need to reduce spending in FY 2010 and 2011
- **Core questions for policymakers**
  - What role do they envision for KHPA in the budget and policy process?
  - What specific policy options would they like to see?
  - What can KHPA do to help policymakers set a course for Medicaid and SCHIP?

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Refocus resources on core program operations

- **Scale back communications, outreach and policy capacity**
  - Eliminate the policy division and Director's position
  - Layoff 5 staff in those
  - Reassign remaining staff to programs operations
- **Consolidate responsibilities within Executive Team to take advantage of specific experience and strengths**
- **Maintain capacity to implement savings and efficiencies identified through transformation and normal program operations**
- **Acknowledge the agency's core accountability to efficiency, transparency, and program improvement**
- **Develop new savings and efficiencies through transformation process and remake the agency to engage in continual review and improvement**

6

Position the State for National Health Reform

- **Ensure appropriate governance and financing for any expansion**
- **General goals in reviewing proposals**
  - Federal reform should maintain or reduce state cost
  - Preserve or enhance state flexibility
  - Consider leaving some big choices to states
  - Resolve conflicts between Medicare and Medicaid
  - Improve Federal support for Medicaid infrastructure
- **Looking ahead to the state's potential role post reform**
  - Legislative review of federal reforms
  - Implement specific reforms
  - Increase public accountability and confidence at state level
  - Continued focus on prevention and medical home
  - Managing costs and enhancing financial accountability
  - Addressing Medicaid's enhanced role with core safety net providers
  - Coverage no longer the core question in Medicaid policy

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Help Secure ARRA Funding for Health Information Exchange and Technology

- **ARRA and existing Medicaid statute include substantial funding for the development and advancement of a coordinated HIE and HIT strategy**
- **KHPA's objectives in developing a statewide plan are to achieve:**
  - a medical home
  - meaningful use among core Medicaid providers
  - efficiency and health-improving use of HIT for Medicaid recipients and the uninsured
- **KHPA submitted on Dec. 8th a revised application for ARRA 90% matching funds to develop the State Medicaid Health Information Technology Plan**
  - Addresses need to focus attention on high volume Medicaid providers and those serving the uninsured
  - Includes a detailed assessment and review of the "As-Is" I HIE/HIT landscape
- **Future grant awards will be used to implement a Medicaid HIT plan:**
  - upgrade KHPA's information systems to connect with the state HIE
  - administer 100% Federal incentive payments necessary to support the implementation of certified electronic health record (EHR) technology by eligible Medicaid providers.

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KHPA's Four Year Strategic Plan

- Approved by the Board November 2009
- Reflects Agency's new priorities
- Implemented at each level of the agency
  - Aligning organizational activities with policy goals
  - Aligning individual roles and responsibilities
- Includes many specific performance targets
- Retains KHPA's focus on data and advancing a medical home
- Reflects the wide responsibilities established for KHPA in statute
- Focuses the agency on core programmatic responsibilities, cost management, health outcomes, and continued transparency

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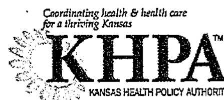

KHPA Strategic Focus: Advancing a Medical Home

- Developing a Medical Home for Medicaid and SEHP was part the KHPA health reform platform of the 2007 Legislative session
- KHPA worked with legislators and stakeholders to codify the definition of Medical Home in statute with SB 81 in 2008
- Kansas participated in the State Quality Institute in 2008-2009 with a project to create a medical home for children in Medicaid and CHIP
- KHPA revised plans for developing a Medical Home model of care with payment reform as a result of the budget deficit
- Participation in the State Quality Institute II continues in 2009-2010 with a project to develop a medical home pilot for high needs/high cost beneficiaries

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KHPA Strategic Focus: Advancing a Medical Home

- As participants in the State Coverage Institute the Kansas team visited Vermont to review how that state is operationalizing a Medical Home
- In 2009 Kansas procured a grant through NASHP to receive technical assistance by participating in the Consortium to Advance Medical Homes
- The Kansas state team is working to develop a plan to implement the Medical Home Model that will be shovel ready when funding becomes available
- The criteria for recognizing Medical Homes will incorporate the CMS definition of meaningful use of health information exchange
- KHPA is working in conjunction with KDHE and stakeholder groups to coordinate planning for HIT and Medical Home in Kansas

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Recent Milestones

- Secured competitive, $40 million grant to replace the state's Medicaid enrollment system and modernize outreach
- Implementing 2008 Medicaid transformation savings and quality initiatives in several areas:
  - More competitive pharmacy pricing
  - Outsourcing management of transportation services
  - Reasonable pricing limits for durable medical equipment
  - Diabetes management initiative for home health workers
  - Two-tier rates and increased use of prior authorization for home health
  - One of the leading states in non-payment for "never" events in hospitals
  - Publishing performance and quality data to improve purchasing
- Nearing completion of 2009 Medicaid transformation recommendations
- Implementing Expansion of SCHIP to 250% of 2008 FPL
- Completing testing for new system to support comparative purchasing for Medicaid and the state employee plan: will implement in 1-2 months

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Impact of Budget Reductions in FY 2009 and FY 2010

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Brief Overview of KHPA's Budget

- **KHPA's FY 2009 budget was about $2.6 billion**
  - $1.36 billion is non-SGF funding for KHPA medical programs
  - $800 million is federal funds passed through to other Medicaid service agencies (SRS, KDOA, JJA, KDHE)
  - $450 million is SGF funding for services and operations
- **KHPA programs and operations are funded separately**
  - FY 2009 operational funding was $23 million SGF
  - Caseload costs are about 20 times larger than operational costs
  - Caseload savings cannot be credited to cost-saving operations
  - The federal government matches Medicaid operations at 50-90%
  - Operational costs for the state employee plan are funded off-budget
- **KHPA FY 2010 budget reductions concentrated on operations**
  - Medicaid caseload protected due to Federal stimulus dollars
  - KHPA operational funding reduced 15.5% versus FY 2009

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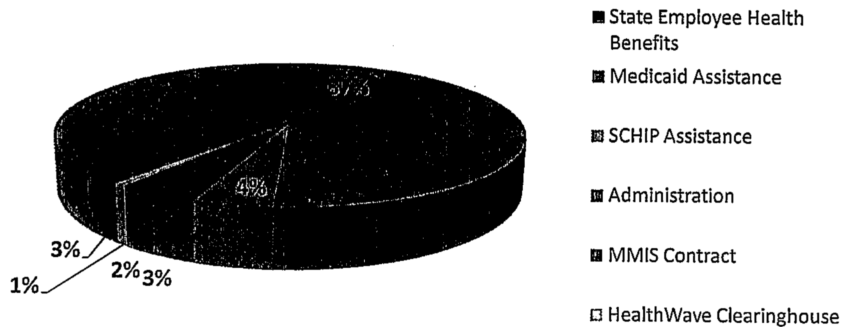
KHPA Total Budget

FY 2010 Approved Budget
excluding off budget and transfers



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Governor's Rescission and 2009 Legislative Reductions: Impact on Medicaid and SCHIP

- **Update: Many thousands of People with Delayed Medicaid/SCHIP Applications through December 2009**
  - Millions of dollars (statewide) in uncompensated or foregone medical care, delayed payments, and foregone federal funding. Needed medical care delayed; negative health outcomes
  - Compliance with Federal deadlines for processing applications at risk
  - Impact reduced by using unexpected contract savings to buy overtime at the Clearinghouse
- **Approximately 40% Cut in Customer and Provider Service**
  - 42 FTE's laid off in July from the Medicaid fiscal agent, HP (@ Forbes Field)
  - Affects 25,000 Medicaid providers' ability to ensure access for their patients; receive prompt payment for services. Potential delays in care and reimbursement
  - Call wait times have doubled since July to nearly 4 minutes
  - Rate of abandoned calls has tripled
- **Staff Layoffs: 13 positions (July 2009)**
  - Another 30+ funded positions held open or eliminated with turnover
  - Cumulative reduction in staffing of 15% as compared to July 2008

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Governor's Rescission and 2009 Legislative Reductions: Impact on State Employee Health Plan

- The timing of past premium increases in the State Employee Health Plan lead to an overfunded reserve account
  - Actuarial sound plans maintain a 15% reserve
- Beginning on Plan Year 2009, The State Employees' Health Care Commission adopted a strategy to gradually spend down the reserve and simultaneously increase premiums to more closely mirror expenditures
- During Plan Year 2009, the Governor and Legislature approved a 7 pay period moratorium on the state paying its portion of employee premiums
  - This decreased the reserve balance by roughly $60 million
- Without significant cost-shifting or rate increases, the KHPA estimates that the 2011 reserve balance will be $3.6M and the plan will have a deficit of $37M in 2012.

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Reduction Options Included in FY 2011 Budget Submission

- Streamline Prior Authorization in Medicaid
  - $243,000 SGF/ $952,000 AF
- Mental Health Pharmacy Management
  - $800,000SGF/ $2.0M AF
- Align Professional Rates in Medicaid
  - $3.6M SGF/ $10.2M AF

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FY 2010 Governor's State General Fund Allotments *July 2009*

- FY 2009 Caseload Savings ($5,300,000)
- Expansions to Pregnant Women ($524,000)
- Increased FMAP Rate ($6,300,000)

- No impact on current services

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FY 2010 Governor's State General Fund Allotments *November 2009*

- Across-the-board 10% reduction in Medicaid provider rates
  - Applies to all Medicaid agencies, all provider types
  - Effective for dates of service beginning January 1st
- $1.13 million SGF ($2.5 million all-funds) reduction in KHPA's operating budget
  - Cumulative 20.5% reduction since approved FY 2009
  - Allotment represents 5% reduction on FY 2009 base
- $1 million SGF reduction in funding for SCHIP services
  - Growing backlog likely to reduce pressure on funding
- Limitation on MediKan benefits to 12 months

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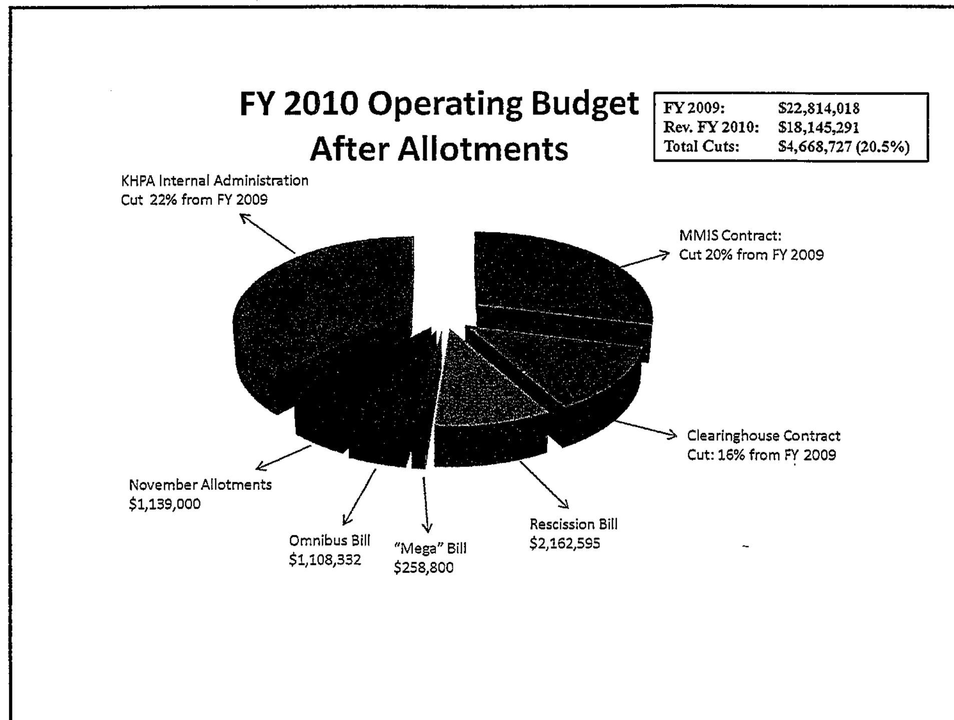

Summary of November 2009 Allotment for KHPA Operations

- Freeze KHPA staff overtime and reduce KHPA staff through attrition (109,000) SGF
- Eliminate extra contract funding dedicated to the Clearinghouse eligibility backlog (140,000)SGF
- Cut State staff overtime dedicated to the Clearinghouse eligibility backlog (60,000) SGF
- Reduce scope of services in the Clearinghouse contract (197,000) SGF
- Amend verification policies and reduce call center capacity at the eligibility Clearinghouse (233,000) SGF
- Lapse funds from FY 2009 (150,000) SGF
- Eliminate the call center for Medicaid providers and significantly reduce call center capacity for Medicaid beneficiaries (250,000) SGF

22

Focus: Eliminate Added Capacity at the Eligibility Clearinghouse

- Extra contract funding and state staff overtime dedicated to the eligibility Clearinghouse backlog
- Loss of funding will lead directly to growth in the backlog of applications, estimated backlog in June 2011 of 33,000
- Growing backlog will result in delayed or foregone medical care for beneficiaries and a loss of revenue for providers
- Created the potential violation of federal 45 day processing time requirements
- Threatens compliance linked to ARRA funding
- Potential loss of up to $11 million in CHIPRA bonus payments
- Potential threat to $40 million HRSA grant for improved eligibility operations

23

Focus: Amend Policies and Reduce Services at Clearinghouse

- Reductions are designed to achieve additional savings without adding to the backlog
- Amending verification policies will speed and simplify application processing but also involves a risk of a higher error rate
- Cutting customer call center capacity by one-third will reduce contractor's capacity to assist beneficiaries
- Eliminating the Quality Assurance unit will weaken KHPA's ability to monitor whether the contractor is meeting performance expectations

24

Focus: Examples of Simplifications to Medicaid/SCHIP Applications

- Self declaration of child support
- Eliminate trust test for "Caretaker Medical" (low-income parents)
- Self declaration of pregnancy
- Eliminate mid-year reporting for Transitional Medical recipients
- Continuous 12-month eligibility for caretaker medical (parents)
- Change income calculation for new applicants with new jobs
- Focus state workers on oversight and processing, not duplication
- Rely on Department of Labor wage information
- Pre-populate review form with lessened verification requirements
- New HW application designed to get questions answered accurately and to obtain necessary information

25

Focus: Eliminate Provider Call Center and Reduce Customer Service

- Option eliminates all Medicaid provider service and reduces customer service at the fiscal agent (HP)
- Fiscal agent receives 250,000 calls per year from providers and beneficiaries, those callers will now be directed to a web portal for information
- Call volume may divert to KHPA staff, but we have no capacity to manage the increase
- Payment accuracy likely to decline, resulting in higher caseload coasts costs
- No in-person training for new providers or changes in billing without the Provider liaisons
- Strain in relationships with Medicaid Providers
- Increase in payment appeals

26

Provider Response to Medicaid Budget Reductions

- Rate reduction has prompted a strong reaction from a wide spectrum of providers
- Impact likely to vary by type of provider
- Impact of rate cuts different if providers view it as permanent
- Providers have expressed some of their deepest concerns over the reductions in customer service
- Many have expressed concerns about the impact reductions will have on access to providers for Medicaid and SCHIP recipients

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Next Steps for KHPA

28

Ongoing Priorities

- Operationalize required budget reductions
  - Work with stakeholders to redefine provider relationship
  - Identify alternatives for customer service
  - Maintain oversight and find opportunities to move forward
- Respond to requests for budget analysis and options
- Prepare contingencies for Federal health reform
- Apply Federal and private grant funds to plan and implement HIE and HIT, and design a pilot for the medical home
- Successfully implement SHAP grant to modernize eligibility systems and outreach
- Complete major projects and federal initiatives and focus on data-driven program management

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

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KATCH Project Summary
(HRSA Grant)

On September 1, 2009, KHPA was awarded a grant by the Health Resources and Services Administration (HRSA), a division of the U.S. Department of Health and Human Services. KHPA applied for HRSA's State Health Access Program (SHAP) grant that sought to support states that were expanding or starting programs that would provide insurance for the uninsured. Based on Kansas' recent commitment to expand the Children's Health Insurance Program (CHIP) to the 2008 250% FPL, KHPA asked for the grant in order to fund additional outreach and a new eligibility system. HRSA awarded KHPA the amount requested for the first year, $1, 930,490, and recommended subsequent grant awards (KHPA must apply for continuing grants each year, but these grants are non-competitive) also in the amounts originally requested for the following four years--$9,432,124; $9,635,813; $9,488,919; and $9,832,096 respectively—for a total grant award of $40,319,442. Of that amount, $28,837,500 is budgeted for the procurement of a medical program eligibility system. The State is expected to match the grant amounts by 20 per cent. A contribution of $200,000 by the Kansas Health Foundation and in kind contributions of staff salaries for the existing KHPA staff who will be working on the project and their related expenses meet the matching requirement for year one. In addition to the in kind contribution by KHPA, the money appropriated by the Kansas Legislature for the expanded CHIP population is used to meet the matching requirement in subsequent years. No additional money is being requested for matching the grant amounts.

The Kansas Access to Comprehensive Health (KATCH) project includes the expansion of health insurance coverage to children below 250% of FPL under the current Children's Health Insurance Program (CHIP). Money has been appropriated by the state legislature to fund the administrative costs of additional application processing and to fund the cost of coverage. However, critical infrastructure investments to support any expansion of coverage are long overdue. Kansas currently is dependent on a mainframe based eligibility system that was implemented 22 years ago and no longer supports public medical programs as they have evolved. Simple policy changes or expansions of existing programs require nearly a year to implement and require significant manual work-arounds. Some public insurance programs require determinations to be done off the system (e.g., paper, spreadsheets) and then the system has to be "tricked" to actually enroll eligible beneficiaries. This introduces error, reduces efficiency, and has made it impossible to acquire and track data to analyze eligible and enrolled populations. The limitations of the system also prevent designing new insurance programs that are not based on the linkage between welfare and health care that remain infused into the current eligibility system. This key piece of antiquated infrastructure makes it very difficult to cover new groups of people, and is a barrier to efficient and effective enrollment.

The KATCH project is based on Kansas' most recent investment in health care reform, which is the expansion of coverage to uninsured children of working families. The system that is envisioned will certainly benefit other populations, but the initial target is the expansion population along with other currently eligible but unenrolled children and pregnant women. As is the case in many states, Kansas has a significant number of children who we believe currently meet the guidelines for coverage in CHIP or Medicaid, but remain unenrolled and uninsured. In addition, low income women tend not to enroll in public health insurance until later in their pregnancies, reducing the effectiveness of prenatal care. More detail on this is explained in the narrative submitted with our grant application.

We believe that there are two primary barriers that keep eligible, uninsured individuals from enrolling. First, KHPA believes that the mail-in process created when CHIP was initially implemented in 1999 is an extremely efficient model for managing "low-touch" (more self-sufficient) families; however, some families require more personal involvement, follow-up, and interaction. That interaction must occur in places where they are already likely to be. The second barrier really springs from the first. Kansas does not have the modern technology required to be in the locations where uninsured people present themselves and to do the follow-up information gathering necessary to enroll uninsured, hard-to-reach populations. KHPA estimates that approximately 20,000 uninsured children are currently eligible and 9,000 additional uninsured children will be eligible under the expansion. New programs like these are far less effective without the systems required to enroll people into those programs. Expansions such as those under consideration in Federal health reform proposals would be impossible without a new system.

Our current enrollment model allows people to access the program in two ways. People can choose to go to an SRS office to fill out a paper application or they can obtain one by calling a toll free number, complete it, and mail it in. (See Figure 1). The

Department of Social and Rehabilitation Services (SRS) is the state's human services agency and is separate from KHPA, but does Medicaid and CHIP determinations on behalf of KHPA. SRS used to have an office in all 105 Kansas counties, but reduced

Current Model

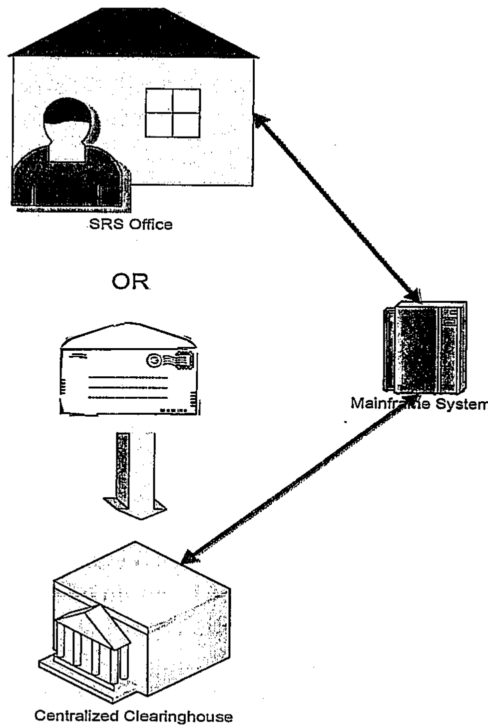

Figure 1

that number to around 60 approximately six years ago. SRS established "access points" in communities so that people could obtain information and applications for different types of assistance within their communities, but the local presence of the SRS office has disappeared from many counties. Kansas is diverse ranging from the major metropolitan Kansas City area on the border with Missouri to the frontier regions of western Kansas and literally every kind of community in between. Many people in western Kansas now have to travel long distances to get to an SRS office. Toll free numbers have been established, which work well for some people (doing business via mail and over the phone) but not well for others. Much of the burden of seeking out assistance with medical coverage has been shifted to the individual in need, reaching out to an SRS office or KHPA's centralized enrollment process.
KHPA's enrollment model also needs to focus on some smaller sub-populations within Kansas that are hard to reach, such as Native American populations. There are several reservations in different parts of Kansas. Evidence suggests that some of these sub-populations are under-represented in terms of enrollment, while the proportion of those sub-populations who are eligible tends to be higher.

KHPA's vision for effective outreach and enrollment calls for a greater presence "on the ground" in clinics, with community resource partners, in tribal settings, and in other public venues where enrollment can occur with varying levels of assistance. The KATCH project includes funding for 12 out stationed workers and a supervisor. The out stationed eligibility workers will be placed in locations around the state, such as community health clinics, where the uninsured go to receive care. They will be able to do eligibility determinations on site. KHPA's vision is that these workers would also be able to perform outreach activities in the surrounding areas and to do full eligibility determinations at those locations.

KHPA's vision for effective outreach and enrollment is to leverage community involvement with minimal public investment. A key component of the KATCH project is to enlist community partners who routinely work with the uninsured and have them assist individuals in filing applications for assistance. The grant includes funding for three outreach trainers who will work to develop this network of community partners and train them on how to assist with properly completing applications and acquiring the necessary documentation and verification.

To further leverage limited state resources, KHPA plans on expanding our network of presumptive eligibility sites. Presumptive eligibility allows non-state staff, such as the staff of a clinic, to do an initial "presumptive" determination of eligibility for children and pregnant women in order to begin providing coverage right away. This must be followed up with a full determination, however, to maintain Federal matching funds for these expenses. There currently are four presumptive eligibility sites, but there is no online presumptive eligibility screening tool to effectively allow for consistent application of rules by clinical staff and the presumptive determination still has to be followed up with a paper application. This makes expanding presumptive eligibility with our current resources infeasible.

KHPA also plans on placing computer and scanning equipment in up to 250 public locations around the state such as libraries, places of worship, or other locations where the proprietors are interested in allowing people to apply from their location. At these locations a kiosk or workstation will support people in filling out an online application and scanning the necessary verification in order to submit a complete application all at once.

Finally, for those who have access to the Internet in their own homes or the homes of friends or family, the online application will be available for them to submit an application online. If they can scan documents at home, they can e-mail them in, or if they can go to one of the public locations and scan them in there. None of this replaces the current model, but supplements the current paper-based model. People can still use the mail-in process or can still go through their local SRS office. The hope is, however, people will use electronic means more and more.

All of these things are to address the first barrier—having more local contacts so that KHPA can go where uninsured people are and enroll them in public health programs. This leads to the second barrier—the technology to actually accomplish this.

In order to make significant strides in enrolling children who are already eligible and pregnant women earlier in their pregnancy, as well as reaching the estimated 9,000 additional children anticipated under this expansion, KHPA requested $28,837,500 over the five years of the grant in order to obtain a web based eligibility system that includes the online application and the presumptive eligibility screening tool. This amount is an estimate based on preliminary work KHPA has done over the past two years investigating the types of systems available, what other states are doing, and what is on the horizon. KHPA's vision is that we will procure a system that will meet KHPA's current and future needs for access and program flexibility (See figure 2).

New Model

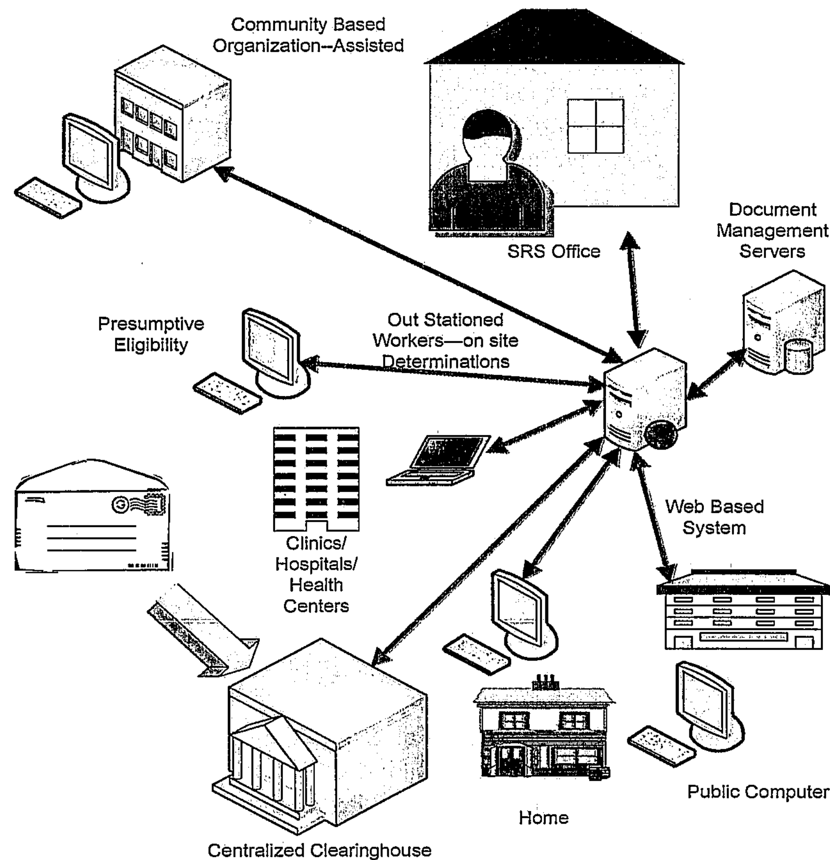

Figure 2

KHPA envisions a service oriented architecture (SOA) based system that is modular and flexible, allowing for easy adaptation and reuse as well as data sharing with other entities and systems. The system will necessarily be rules driven in order to accommodate quick policy and program changes to the highly complex set of Medicaid eligibility criteria. The rules engine also shifts the burden from the current reliance on an experienced, extremely knowledgeable workforce to implement and apply policy accurately, consistently, and equitably to the system itself. Workers will still need to be knowledgeable, but the learning curve will not be so steep and program success will not be nearly as dependent on people.

A workflow engine will be incorporated in order to allow for efficient processing of applications and case maintenance tasks. Tasks can be assigned to different people who may be located many miles apart. Location of those doing the work will be much less important now than it has been in the past. In addition, the system will need to hook into KHPA's document management system, ImageNow, via open application programming interfaces (APIs). This allows for a "paperless" processing system. Any paper that comes through the door stays at the door. Once the paper documents are imaged, the document management system allows for the documents to be accessed by multiple people at the same time and to not have to wait for retrieval of a file from the file room. It also extends the reach of a field worker or Clearinghouse worker as all those with access to the system will be able to see the appropriate files regardless of their locations.

An online application allows for the application data to be delivered in an electronic format, eliminating redundant data entry. The electronic record this creates becomes the case from which eligibility is determined and is linked to the relevant imaged documents. Again, location is much less important because the web based eligibility system will allow secure access from a desktop PC or a laptop accessing the Internet via a wireless air card or Wi-Fi. Naturally, security will be a high priority in order to protect the transmission and sharing of this extremely sensitive data. However, none of the data need be resident on a PC or laptop. A virtual desktop can be utilized for remote access and all processing occurs on servers in a central location.

Supplementing the online application is the presumptive eligibility tool. This is the online application plus a screening tool authorized to be used in certain locations that will produce a temporary eligibility record and allow for immediate coverage of services. By incorporating this into the online application, families do not have to fill out a paper application in addition to providing information during the presumptive eligibility process.

All of the technology described leverages KHPA's limited resources to expand outreach and enroll the uninsured. Without this investment in technology, effective outreach cannot occur. The current technology will allow KHPA to have out stationed workers in other locations, but they will not be able to travel from the workstation in their office to do additional determinations. The system KHPA currently uses does not support the varied eligibility rules for our current programs and requires many manual workarounds. This antiquated system does not allow for the expansion of presumptive eligibility or community based enrollment. It does not include, nor could it support, an online application that makes applications more user-friendly, requires less expertise and training to navigate, and creates an electronic case record automatically.
To sum up, the new technology serves as a key building block for a strategy that leverages community resources and individual initiative to eliminate barriers between eligibility and enrollment. With full funding for both the technology and other resources needed to connect with community resources and individual applicants, the grant enables KHPA to make substantial progress in achieving its vision for effective and efficient enrollment in public insurance programs.

KANSAS

DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

Don Jordan, Secretary

Joint Health Policy Oversight Committee
December 17, 2009

2010 Budget Reductions

Laura Howard, Deputy Secretary

For Additional Information Contact:
Katy Belot, Director of Public Policy
Patrick Woods, Director of Governmental Affairs
Docking State Office Building, 6th Floor North
(785) 296-3271

Joint Health Policy Oversight
Date: 12/17/09
Attachment: 3

KANSAS
DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

2010 Budget Reductions

Joint Health Policy Oversight Committee
December 17, 2009

Thank you for the opportunity to appear before you today to discuss the impact of FY 2010 budget reductions on the Kansas Department of Social and Rehabilitation Services.

The SRS FY 2010 SGF budget is 15.7 percent lower than the FY 2008 actual SGF and has been reduced $147.2 million SGF since the beginning of the FY 2009 Legislative session. While the ARRA enhanced FMAP reduction was $66.9 million SGF, the remaining $80.3 million in SGF reductions was achieved by cuts in administration and assistance programs.

Attachment A details the FY 2010 budget reductions approved by the 2009 Legislature and the subsequent reductions as part of the two 2009 allotments.

Throughout the reduction process, SRS has focused its efforts on preserving services for the most vulnerable Kansans. In addition, the agency has tried to minimize the effect of its reductions on customers to the best extent possible. For example, participants in the Grandparents as Caregivers program that met certain income requirements were able to receive assistance from the Temporary Assistance for Families (TAF) program. Approximately, 61.6 percent of these individuals chose to transition over to TAF. Additionally, those young adults age 18 or older that were released from the Secretary's custody are now receiving independent living assistance and the youth age 16 or 17 in non-abusive situations that were diverted from SRS custody are now receiving in-home prevention services.

Unfortunately, the effect of some reductions could not be minimized. Reducing General Assistance eligibility for Tier Two cases from 24 months to 12 months affects approximately 2,000 adults with severe physical and mental impairments. The monthly grant for those individuals who still receive General Assistance has been reduced 40 percent to $100 per month. These same reductions to MediKan Mental Health recipients have affected 358 individuals.

Reductions to various grants will have a noticeable effect across the state. Grants to community mental health centers have been reduced by approximately $11.0 million, and it is estimated that 3,827 individuals will see services reduced or eliminated during FY 2010. Grants for development disability assistance have

been reduced by approximately $8.1 million, resulting in reduced or eliminated services for an estimated 2,450 individuals.

Attachment B details the effect of all reductions that have been made thus far.

SRS continues to take steps to manage frugally in these uncertain times. In the fall of 2008, we recognized that cuts in programs and services were likely, so we implemented a hiring freeze to contain salary expenditures. During the freeze, our vacant positions have increased 50 percent. This means that almost 400 fewer staff today than at the beginning of FY 2008. Sixty percent of these vacancies are in our regional offices. 100 of those reductions have occurred since the beginning of FY 2010 because we are only filling mission critical positions. Our staff will be reduced even further because of layoffs resulting from restructuring efforts going on throughout the agency. The restructuring process has also resulted in reallocation and lower pay for some employees. Overall, 115 people have been affected by the restructuring either through layoffs or reallocations.

While we have decreased the number of staff, the caseloads are growing because of the recession and more and more people are requiring assistance. Since FY 2008 the caseloads have increased 7.5 percent. The increased number of cases and the decreased number of staff have resulted in a 10.0 percent increase in workload per case-carrying position. Please see Attachment C for more information on reduced staff and rising caseloads.

When looking at further reductions, it's important to keep in mind that SRS must perform certain statutory duties that are tied to protection and safety in concert with duties prescribed by other systems such as law enforcement and the courts. These duties include investigating child and adult abuse; caring for children committed to the Secretary's custody; and providing care and treatment to persons committed to the state psychiatric hospitals, the state security hospital, and the sexual predator treatment program.

A second category of services provided by SRS is tied to federal programs and funding. Federal funding represents approximately 55 percent of the total SRS and Hospitals budget. As a condition of receiving federal funds, SRS must administer federal programs in compliance with mandatory requirements. These requirements include providing matching funds or maintaining certain levels of state funding. A related set of activities are those which, while not mandated in and of themselves, have some connection to a state or federally mandated activity. For example, the Home and Community Based Services waivers are not mandated services under Medicaid; however, in the absence of these services, individuals would likely access inpatient or nursing facility care, which are more costly and federally mandated services.

Reductions in the SRS budget are also restricted by the ARRA funding requirements. To qualify for the enhanced FMAP, states may not enact policies that are more restrictive than their FY 2008 state plan. In addition, other programs are subject to non-supplantation provisions under ARRA.

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It should also be noted that further reductions of the hospital budgets would necessitate the need to cease voluntary admissions at the Mental Health Hospitals and the closure of patient units. Current shrinkage rates at the Mental Health Hospitals are running from 6.9 percent to 14.0 percent. Any further reductions, without reducing patient census, could put the hospital at risk of losing their license and certification.

The pie chart in Attachment D demonstrates which areas of the SRS budget include budgetary restrictions and which areas of the budget have no restrictions.

Because of these restrictions, the fact that caseload carrying staff are already at levels previously considered unacceptable, and the depth of reductions already taken, the remaining options for further reductions involve the complete elimination of programs, including General Assistance; CMHC and DD grants and state aid; and funeral assistance.

SRS has already made numerous changes to achieve efficiencies and meet its current budget. Contracts have been renegotiated, including the foster care contract for a savings of $14.1 million. Additionally, changes were made to Child-In-Need-of-Care policies releasing certain individuals from SRS custody while maintaining support services, resulting in a savings of $5.2 million.

SRS has made several reorganization efforts to create efficiencies in how we manage and deliver our services. You may recall that the FY 2003 and FY 2004 allotments prompted a service delivery redesign that resulted in the closing of over 60 local offices and placing staff into strategically located customer service centers. Regional offices began a major restructuring effort again this fall in order to redirect as many resources to the front line as possible. With the most recent reorganization, SRS regional offices will have fewer assistant directors and managers, and there will be higher supervisor to staff ratios. In total 88 regional staff, primarily management and administrative positions, are affected by this reorganization. The majority of staff at the regional levels have elected to accept reallocation to more mission critical job functions, and transition to new duties is underway. Generally, these reallocations will involve salary reductions of at least 2.5 percent.

Reorganization plans were also developed at the central office level in order to perform our most critical functions with a reduced workforce. As a result, 18 central office positions will be laid off effective December 26, 2009

Furthermore, there are currently eight protection report centers that receive reports of child abuse/neglect and adult/abuse neglect via a single toll free number. These centers will be consolidated to two locations. Operations will remain in the Finney State Office Building in Wichita and the Docking State Office Building in Topeka, and the other regional centers will be shut down effective January 1, 2010. The consolidation will ensure standardization and consistency in the handling of reports of abuse and neglect. Approximately 17 positions will be eliminated as a result of the consolidation.

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The current state budget situation has required us to review all of our programs for efficiencies. The most recent allotment issued by the Governor will result in policy changes we would prefer not to do but are necessary to save money to meet our current budget. These changes include limiting personal care assistant hours and eliminating dental care for the DD Waiver, PD Waiver, and TBI Waiver; limiting assistive services to crisis only for PD Waiver and TBI Waiver; and eliminating emergency respite care in the DD Waiver.

The Hospitals are also implementing various personnel actions, unit consolidations, and other operating reductions to reduce expenditures in both FY 2010 and FY 2011. Major changes include closing the Youth Services Unit at Larned State Hospital; consolidating a home in FY 2009 and another home in FY 2010 at KNI; and closing Willow cottage at Parsons State Hospital and consolidating these residents into another cottage.

As you can see, we are making numerous reforms, consolidations, policy changes, and other efficiencies just to achieve the current level of funding. As previously indicated, if additional reductions are required, we will be looking at eliminating total programs to attain further savings.

Attachment A
List of SRS/Hospitals FY 2010 Reductions

Priority	Description	SGF	All Funds	Cumulative SGF	Cumulative Percentage
1	Reduce CMHC Grants	2,500,000	2,500,000	2,500,000	0.33%
2	Reduce AAPS Grants	600,000	600,000	3,100,000	0.41%
3	Reduce DD Day & Residential and Family Support Grants	2,000,000	2,000,000	5,100,000	0.67%
4	Miscellaneous OOE Reductions	1,164,509	1,164,509	6,264,509	0.83%
5	SGF/Fee Fund Switch	2,200,000	–	8,464,509	1.12%
6	Renegotiate Foster Care	14,099,718	15,056,820	22,564,227	2.97%
7	Limited Adoption Contract	1,399,228	1,399,228	23,963,455	3.16%
8	Increase Vacant Positions	1,785,405	2,078,175	25,748,860	3.39%
9	Cancel BARS Contract	100,000	100,000	25,848,860	3.41%
10	Reduce Funeral Assistance	290,000	290,000	26,138,860	3.44%
11	Shift $600,000 AAPS Grants to Gaming Revenue/Reduce	800,000	372,403	26,938,860	3.55%
12	Integrate Grandparents as Caregivers (GAC) into Temporary Assistance for Families (TAF)	1,165,320	1,165,320	28,104,180	3.70%
13	Reduce DD Day & Residential and Family Support Grants	2,000,000	2,000,000	30,104,180	3.97%
14	Reduce CMHC Consolidated Grants	2,000,000	2,000,000	32,104,180	4.23%
15	Release CINCs from SRS Custody @ 18	1,532,318	1,687,876	33,636,498	4.43%
16	No SRS Custody for CINCNANs 16 & up	2,280,052	2,561,769	35,916,550	4.73%
17	Limit General Assistance to 18 mos.	2,886,229	2,886,229	38,802,779	5.11%
18	Limit MediKan Mental Health to 18 mos.	2,660,742	2,660,742	41,463,521	5.46%
19	Fund Longevity with Existing	1,955,884	1,955,884	43,419,405	5.72%
20	FMAP Rate Increase (GBA)	61,080,967	–	104,500,372	13.77%
21	Remaining Moratorium on Death and Disability	497,844	895,341	104,998,216	13.83%
	Everything above this line represents a Mega bill reduction (Items 1-21)				
22	Reduce DD Day & Residential and Family Support Grants	1,163,174	1,163,174	106,161,390	13.98%
23	Reduce Mental Health Grants	2,500,000	2,500,000	108,661,390	14.31%
24	Reduce Substance Abuse Grants	1,400,000	1,400,000	110,061,390	14.50%
25	Miscellaneous DBHS Contracts	489,715	489,715	110,551,105	14.56%
26	Reduce Community Medication Program	560,285	560,285	111,111,390	14.64%
27	Reduce General Assistance (GA) monthly cash grant to $100	1,470,432	1,470,432	112,581,822	14.83%
28	2.5 percent salaries reduction	2,225,300	5,034,289	114,807,122	15.12%
29	Reduce DD Day & Residential and Family Support Grants	1,625,000	1,625,000	116,432,122	15.34%
30	Other reductions	730,186	730,186	117,162,308	15.43%
31	FMAP Rate Increase (related to unemployment)	1,674,347	–	118,836,655	15.65%
	Everything between these lines represents a reduction taken in the Omnibus bill (Items 22-31)				

Attachment A
List of SRS/Hospitals FY 2010 Reductions

Priority	Description	SGF	All Funds	Cumulative SGF	Cumulative Percentage
32	Additional 2.0 percent salaries reduction	1,483,534	3,356,193	120,320,189	15.85%
33	FMAP Rate Increase (related to unemployment)	4,185,564	--	124,505,753	16.40%
34	TANF Contingency Fund transfer to Dept. of Revenue for Earned Income Tax Credit Refunds*	--	18,687,361	124,505,753	16.40%
Everything between these lines represents the Governor's July allotment reductions (Items 32-34)					
35	10% Rate Reduction on Medicaid	6,172,512	19,263,525	130,678,265	17.21%
36	Reduce DD Day & Residential and Family Support Grants	1,300,000	1,300,000	131,978,265	17.39%
37	Reduce Mental Health Consolidated Grants	3,983,347	3,983,347	135,961,612	17.91%
38	Reduce Salary Budget	747,071	747,071	136,708,683	18.01%
39	Reduce Substance Abuse Grants	275,000	275,000	136,983,683	18.04%
40	Reduce General Assistance (Cash) Tier II from 18 Months to 12 Months ***	288,000	279,605	137,271,683	18.08%
41	Reduce General Assistance Tier II Mental Health from 18 Months to 12 Months	465,552	465,552	137,737,235	18.14%
42	Replace SGF with TANF	2,000,000	--	139,737,235	18.41%
43	Replace SGF with Fee Fund	1,322,800	--	141,060,035	18.58%
44	Replace SGF with unbudgeted ARRA in Hospitals	3,092,047	--	144,152,082	18.99%
45	Reduction in Operating Expenditues in Hospitals	3,002,763	3,002,763	147,154,845	19.38%
Everything between these lines represents the Governor's November Allotments (Items 35-43)					

* This represents a transfer of federal funds to the Department of Revenue and does not represent a reduction in expenditures for SRS.

Attachment B

Reduction	SGF	All Funds	Avg Monthly Persons	How have services that your agency provides been impacted or will be impacted?	Has the public noticed the impact of any reductions that you have made and how are they being affected by the reductions?
Final FY 2010 Appropriation Bill					
Renegotiate Foster Care	14,099,718	15,056,820		The renegotiated foster care contracts preserve essential services and maintain outcomes for children while simultaneously producing a significant amount of savings. The new contracts also create structural efficiencies by consolidating ten contracts into five and by incorporating functions from the adoption contract.	No children are affected by the renegotiation.
Limited Adoption Contract	1,399,228	1,399,228		The revised adoption contract is limited to the statewide adoption exchange and outreach to potential adoptive parents. The recruitment and training of adoptive parents is shifted to the foster care contracts.	No reduction in the pool of potential adoptive parents has occurred. The number of adoptions is projected to rise in FY 2010.
Reduce Funeral Assistance	290,000	290,000		The reduction in funeral reimbursement from $680 to $550 shifts a portion of the burial costs to very low income families who often cannot afford basic needs. The level of funerals in FY 2010 may require a suspension of the program effective May 1, 2010.	Approximately 1,130 families will receive a lower reimbursement for funeral expenses.
Integrate Grandparents as Caregivers into Temporary Assistance for Families (TAF)	1,165,320	1,165,320		Financial assistance to grandparents is continued in the Temporary Assistance for Families program. The policy change required grandparents to cooperate with child support enforcement and removed the more stringent income limit that existed for the Grandparents as Caregivers Program.	Of the 151 families receiving assistance through the Grandparents as Caregivers Program in June 2009, 93 received TAF assistance in July 2009.

Reduction	SGF	All Funds	Avg Monthly Persons	How have services that your agency provides been impacted or will be impacted?	Has the public noticed the impact of any reductions that you have made and how are they being affected by the reductions?
Release CINCs from SRS Custody at Age 18	1,532,318	1,687,876	76	Services to young adults formerly provided through foster care are preserved through independent living assistance. Key services include housing, medical, and continuing education. Since this policy change, the agency has emphasized earlier planning with older foster care children to better prepare them for living independently.	The agency has been working locally in communities regarding implementation and has heard few negative comments. Young adults released from foster care receive the same or expanded services that were received during their stay in foster care. Courts first review independent living transition plans before the release from foster care and have been open in communication with agency if plans do not meet the needs of the young adult.
No SRS Custody for CINC-NANs 16 & over	2,280,052	2,561,769	156	Services to youth age 16 and 17 previously in foster care are now provided through in-home prevention services. These services are aimed at keeping families intact. The savings from this policy are the net of foster care savings and increases in in-home prevention services.	In-home prevention services are more effective and appropriate for these youth. The agency has received very few concerns from families regarding this change in law. We continue to assess and support communities to have capacity to provide in-home services. There have been intermittent frustration expressed from families regarding access to mental health services for these youth and the agency has worked with the family to identify resources in their community for such service.
Limit General Assistance (Cash) Tier II to 18 Months	2,886,229	2,886,229	1,503	No offsetting services are in place for this policy change.	The agency assumes the loss in financial assistance to some of the 1,500 adults with severe physical and mental impairments will be mitigated by the families who care for them, or by local helping agencies. In many cases, the loss may not be replaced. Equally important, these adults lost medical coverage.
Reduce CMHC Grants	4,500,000	4,500,000	1,573	These grants are used to serve persons with mental illness who do not have the ability to pay, especially persons with a severe and persistent mental illness (SPMI) and children with a serious emotional disturbance (SED). To address this funding cut SRS agreed that, for the first time	CMHCs are doing all they can to avoid establishing waiting lists. This includes cutting administrative support staff who do not provide treatment, continuing to freeze wages, reducing clinical supervision, and ensuring persons they serve who may be Medicaid eligible are assisted with their eligibility (see

Reduction	SGF	All Funds	Avg Monthly Persons	How have services that your agency provides been impacted or will be impacted?	Has the public noticed the impact of any reductions that you have made and how are they being affected by the reductions?
				ever, CMHCs could begin a waiting list of community mental health services. SRS allows CMHCs to prioritize their services as follows: · First, provide crisis mental health services; · Second, complete inpatient screenings that are not paid in any other way; · Third, serve persons in the target population who do not have the ability to pay including: · Youth who have an SED; · Adults who have an SPMI; and · Persons who, due to their mental illness are: o At risk of requiring inpatient mental health care and treatment; or o Causing or at serious risk of causing serious harm to themselves or others; or o Likely to experience serious deterioration in their mental health if they do not receive community mental health treatment; or o Homeless or at risk of homelessness; or o At risk of being jailed. · Fourth, actively participate in discharge planning for persons served in a state mental health hospital, nursing facility for mental health (NF/MH), or psychiatric residential treatment facility (PRTF); · Fifth, serve persons not in the target population who do not have the ability to pay. These people may need to wait for services until they decompensate and are in need of immediate services. These effects will be exacerbated when persons lose MediKan	Medicaid cut below). When these efforts are insufficient, CMHCs will start waiting lists. County Commissioners recognize the reduction in state support and, when pressed with their own revenue challenges, are beginning to reduce their support for CMHCs. CMHCs will find it difficult to accurately predict when someone needs immediate services that would prevent them from needing inpatient or state mental health hospital services. Admissions to state mental health hospitals that could have been prevented will increase.

Reduction	SGF	All Funds	Avg Monthly Persons	How have services that your agency provides been impacted or will be impacted?	Has the public noticed the impact of any reductions that you have made and how are they being affected by the reductions?
				coverage as a result of reducing eligibility from 24 to 18 months and seek CMHC services provided by grant funds.	
Reduce AAPS Grants (Shift AAPS SGF to fee fund	600,000	600,000	N/A	This shift lessened the program's ability to meet the additional reductions without impacting services.	No public impact on this shift alone.
Reduce DD Day & Residential and Family Support grants	4,000,000	4,000,000	2,450	1. 346 persons who were receiving SGF funded day and/or residential services refinanced to the HCBS/MR/DD waiver. They did not lose services, but may now experience high client obligations as a result of the change in the funding source. 2. 10 persons have lost their day and residential services. 3. 394 persons have lost their family support/subsidy funding. 4. 142 persons have experienced a reduction in their amount of family support/subsidy funding. 5. CDDOs have reduced reimbursement to providers for day and residential services provided through the SGF funded program. 6. CDDOs have used State Aid funds to reimburse for services that were funded through the SGF program thereby decreasing the funding for children's programs and transportation.	The public may be asked to assist with funding children's programs and provide transportation for individuals that no longer have access to those services.
Cancel BARS contract	100,000	100,000	N/A	This work is being performed by another contractor.	No known impact.
Shift $600,000 AAPS Grants to Gaming Revenue/Reduce Expenditures by $200,000	800,000	800,000		While the net effect of this reduction was to be only $200,000, the estimated revenue in FY10 to this gaming fund was lowered after the appropriation bill from $600,000 to $427,597. Because no revenue was expected for many months and due to the uncertain economy, the full	306 fewer individuals have been served during the 1st quarter of FY10 in comparison to the 1st quarter of FY 09. Some programs have closed satellite locations and more individuals are waiting for a treatment slot to become available. Further reductions will continue to impact the availability and

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Reduction	SGF	All Funds	Avg Monthly Persons	How have services that your agency provides been impacted or will be impacted?	Has the public noticed the impact of any reductions that you have made and how are they being affected by the reductions?
				$800,000 (in addition to the $1.4 listed below) was reduced and passed on to providers at the start of FY2010.	access to needed services, especially in the rural and frontier areas of the state.
Reduce MediKan Mental Health eligibility from 24 to 18 months	2,660,742	2,660,742	142	Persons previously eligible for MediKan who need community mental health services will seek services from the CMHCs who will need to provide those services with ever shrinking grant funds. If these persons do not meet the definition for priority populations, they may need to wait and will only be served if they decompensate and are in need immediate services.	See $4.5 million CMHC grant cuts above.
FY 2010 Omnibus Bill					
Reduce General Assistance Monthly Cash Grant to $100	1,470,432	1,470,432	3,231	No offsetting services are in place for this policy change.	The reduction in financial assistance represents an approximate 40% decrease. This reduction affects adults with disabilities that prevent employment.
Reduce Day & Residential and Family Support grants	2,,788,174	2,,788,174	2,450	Same as above. The amounts were combined to reduce the 1st and 2nd quarter payments to the CDDOs.	Same as above.
Reduce Mental Health Grants	2,500,000	2,500,000	874	See $4.5 million CMHC grant reduction above.	See $4.5 million CMHC grant cuts above.
Miscellaneous DBHS Contracts	489,715	489,715		The reduction of these funds limit the ability of DBHS staff to obtain independent, external assistance in the development, implementation and/or review of such program management and infrastructure items as: review of specific accounting and budgeting information from providers, rate study information, rate setting reviews, and federal or other requirements associated with DBHS programs.	Providers will receive slower responsiveness from DBHS on a variety of technical infrastructure issues associated with program management. Independent input into the development of these processes, and review of their implementation, will be limited.

Reduction	SGF	All Funds	Avg Monthly Persons	How have services that your agency provides been impacted or will be impacted?	Has the public noticed the impact of any reductions that you have made and how are they being affected by the reductions?
Reduce Community Medication program	560,285	560,285	174	These funds purchase atypical antipsychotic medication for persons who have no other means to pay for these medications. Without needed medication persons experiencing active symptoms of severe mental illness may decompensate and require more restrictive and more expensive inpatient treatment and unnecessary readmissions.	Fewer people have access to funding for needed mental health medications. The impact is difficult to determine since information about those who do not receive these services has not been compared with other mental health data, such as state mental health hospital admissions.
Reduce Substance Abuse Grants	1,400,000	1,400,000		Short term impacts of these reductions have been identified: 306 fewer individuals have been served during the 1st quarter of FY10 in comparison to the 1st quarter of FY 09. Some programs have closed satellite locations and more individuals are waiting for a treatment slot to become available. Further reductions will continue to impact the availability and access to needed services, especially in the rural and frontier areas of the state. As the result of the reductions in FY 2010, SRS is $3 million short of the maintenance of effort requirements set forth by the Substance Abuse Prevention and Treatment block grant.	KDOC funds for the 4th time DUI offender program were also reduced by 70% in FY 10. As a result, the number of providers able to serve this population decreased from 59 to 20. In addition, only a limited number of outpatient services are available under the new program. This means any 4th time DUI offender who also meets federal poverty guidelines may access block grant funding in order to receive other types of treatment services that may be clinically indicated. This places an even greater demand on the block grant funded system. The effect of single program reductions, when experienced simultaneously, has a grave impact on treatment providers' ability to remain viable and ensure access to needed services.
Jul 2009 Allotment					
TANF Contingency Fund transfer to Dept. of Revenue for Earned Income Tax Credit Refunds	-	18,687,361		The dual purpose of this transfer is to provide financial assistance to working, low income households and to reduce the level of state fund reductions that SRS would have otherwise faced. The use of the TANF Contingency Fund cannot be repeated in the future because of the erosion in the TANF excess MOE which, in turn, affects the TANF work participation rate.	No SRS programs were impacted by this reduction. However, had the funds been used for expanded services rather than replacing state funds, valuable one-time services to TANF families could have been considered.

Reduction	SGF	All Funds	Avg Monthly Persons	How have services that your agency provides been impacted or will be impacted?	Has the public noticed the impact of any reductions that you have made and how are they being affected by the reductions?
Nov 2009 Allotment					
Reduce General Assistance (Cash) Tier II from 18 Months to 12 Months	288,000	279,605	480	No offsetting services are in place for this policy change.	The agency assumes the loss in financial assistance to some of the 480 adults with severe physical and mental impairments will be mitigated by the families who care for them, or by local helping agencies. In many cases, the loss may not be replaced. Equally important, these adults will lose medical coverage.
Replace SGF with TANF	2,000,000	-	10,878	This measure uses $2.0 million of the $6.2 million in projected TANF balances at the close of FY 2013 to replace state funds. If TAF caseloads rise more than projected, other reductions may become necessary.	No SRS programs are impacted by this reduction. Future impacts will depend on the growth in the TAF caseload.
10% Medicaid Reimbursement Rate Reduction – Mental Health Services	6,172,512	13,091,013		This is will reduce community mental health Medicaid payments by at least $4.8 million in the last six months this year. This will seriously affect the financial viability of many CMHCs. As many as one third of CMHCs experienced an operating loss in their last reported fiscal year. The Medicaid rate reduction will worsen this situation and could threaten the ability of some CMHCs to remain open. Some CMHCs have already begun laying off staff. Other effects will be better known in the weeks ahead once CMHCs have a chance to assess the impact. The impact is similar for private community mental health Medicaid providers. However, since they are not statutorily required to provide public mental health services, private providers may simply choose to discontinue serving Medicaid recipients, thereby reducing their choice of providers. Nursing Facilities for Mental Health	Reductions have not taken effect, so affects have not yet been felt.

Reduction	SGF	All Funds	Avg Monthly Persons	How have services that your agency provides been impacted or will be impacted?	Has the public noticed the impact of any reductions that you have made and how are they being affected by the reductions?
				(NF/MHs) and Psychiatric Residential Treatment Facilities (PRTFs) will be seriously affected by these cuts. NF/MHs are the lowest reimbursed of the nursing facilities. Both NF/MHs and PRTFs must meet required federal Medicaid certification (licensing) rules. Meeting these requirements at current reimbursement rates is difficult for some facilities. Funding cuts may result in increased serious deficiencies, some that put residents at risk of harm. Some facilities may choose to close or be forced out of business. Residents in these facilities will need a home with intensive supervision for them to live successfully in the community or they will be referred to state mental health hospitals, who are also experiencing budget cuts. The number of families in crisis will increase if children with a serious SED are returned home. There could also be an increase in homelessness for adults with an SPMI.	
10% Medicaid Reimbursement Rate Reduction – Community Supports & Services	6,175,512	13,091,013		Projected Impact: 1. We will see larger group living arrangements. Providers will move individuals from 2-4 bed homes into 5-7 bed homes to decrease the number of staff needed. 2. May see an impact on the quality of care due to a higher staff to consumer ratio in the day and residential settings. 3. Providers that have not been fiscally sound will go out of business. 4. Smaller providers may be forced out of business. 5. Individuals who self-direct their	Rate reduction to be implemented January 1, 2010.

Reduction	SGF	All Funds	Avg Monthly Persons	How have services that your agency provides been impacted or will be impacted?	Has the public noticed the impact of any reductions that you have made and how are they being affected by the reductions?
				services will not be able to find attendants due to the decrease in the hourly rate.	
10% Medicaid Reimbursement Rate Reduction – Addiction and Prevention Services				The network of providers who deliver substance abuse services in Kansas has relied on Medicaid funding to offset lower rates of reimbursement in other publicly funded programs. As a result, this 10% reduction will be experienced by providers, and ultimately, by consumers at a much higher percentage. Capacity for needed services will continue to shrink and waiting lists for this population may become a reality. This reduction in rates will also reduce the managed care organization's amount they receive for administration. In this case, a reduction in the number served is not anticipated so essentially the managed care organization will have to look for savings elsewhere which may impact the state's ability to meet CMS requirements.	While the full impact of the reductions will not be realized for several months, the actions taken by providers in response to the earlier reductions will continue and accelerate. These actions include: --Reduced medical services at the treatment center which result in more referrals to the hospital emergency room --Reduced dollars for client medications which ultimately effects client outcomes --Reduced dollars for transportation of clients --Loss of a Program Chaplain --Reduced full time positions to part time to eliminate employee benefit costs --Not being able to fill open positions. Transferring staff duties to cover the mandated duties of the open position --Considering layoffs and furloughs as a last ditch effort to reduce costs
Reduce DD Day & Residential and Family Support Grants	1,300,000	1,300,000	2,450	Projected Impact: Further reductions in the number of individuals that receive family support/subsidy. Individuals will loss day and residential services that are funded the SGF program. Decreased payments to day and residential providers for those individuals that do continue to receive services.	
Reduce Mental Health Grants	3,983,347	3,983,347	1,380	See the $4.5 million and $2.5 million CMHC grant cuts above. These cuts are made worse by making them in the last six months of the year. This explains the disproportionately high impact of persons served. These	Waiting lists will have to be established and all of the potential effects listed in the $4.5 million grant cut will occur in many places throughout the state.

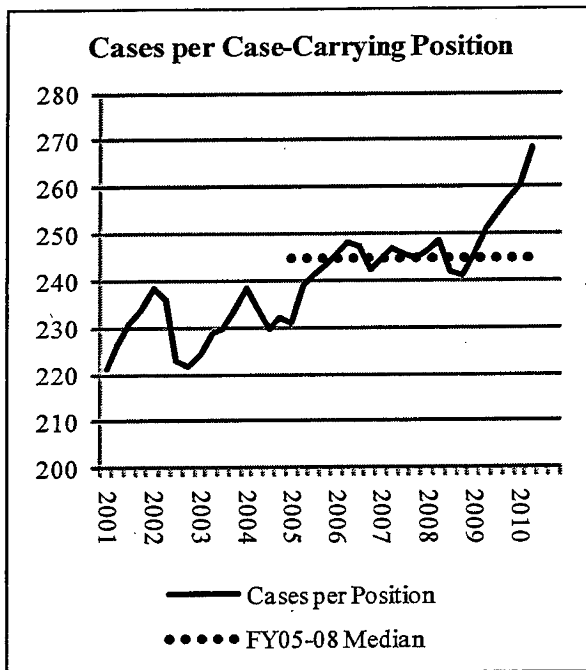
Reduction	SGF	All Funds	Avg Monthly Persons	How have services that your agency provides been impacted or will be impacted?	Has the public noticed the impact of any reductions that you have made and how are they being affected by the reductions?
				effects will be further exacerbated when persons lose MediKan coverage as a result of reducing eligibility from 18 to 12 months and seek CMHC services provided by grant funds.	
Reduce Substance Abuse Grants	275,000	275,000		This reduction, as well as a portion of the $2.2 million listed above, was absorbed primarily by prevention related grants and contracts. *These agencies have also received grant reductions from the Juvenile Justice Authority*. As the lead agency for substance abuse prevention in the state, these reductions will challenge SRS' capacity to meet federal requirements, address emerging issues and assist communities and coalitions working to reduce underage drinking and other health concerns. The contractor responsible to ensure that Kansas is in compliance with the Synar amendment has also been reduced. While Kansas is experiencing favorable outcomes this year, failure to meet state Synar compliance goals in 2005 resulted in a fine of over 2 million dollars in 2005.	The regional prevention system had already experienced level funding for nearly 10 years prior to the budget reductions. As a result, some agencies have been forced to reduce the total number of coalitions they work with and limiting their support to selected "targeted communities". In some communities, many coalitions have folded or are on the brink of disbanding. Attempts are made to respond to requests for prevention services in those communities, but travel there has been restricted which impacts the provider's ability to mobilize and build the capacity of residents. As a result, prevention agencies in Kansas are providing less prevention services in fewer areas. Some agencies have reduced staffing and/or not filled open positions. As our delivery of services to our communities and coalitions decrease, we can expect the rate of substance abuse to increase. As substance abuse rates increase, more demands for social, educational and correctional services will increase. Some regions are also experiencing a boom in population growth without an increase in staffing, thus impacting the provider's ability to serve the region they are responsible for.
Reduce MediKan Mental Health Eligibility from 18 months to 12 months	465,552	465,552	216	See MediKan eligibility reduction from 24 to 18 months above.	See MediKan eligibility reduction from 24 to 18 months above.
Reductions of Operating Expenditures in Hospitals	3,002,763	3,002,763		The Mental Health Hospitals are expecting to save SGF through	These actions have a direct impact on the patients these facilities operate.

Reduction	SGF	All Funds	Avg Monthly Persons	How have services that your agency provides been impacted or will be impacted?	Has the public noticed the impact of any reductions that you have made and how are they being affected by the reductions?
				various personnel actions and OOE reductions. At LSH these actions include eliminating the clothing and supply function, the print shop function; reducing the capacity of the Female Unit on the SSP from 30 to 20 beds, and increasing vacant positions (shrinkage). At Osawatomie savings in other operating expenditures will be achieved by deferring some routine maintenance and having repairs and maintenance performed only where absolutely necessary. Inventories of office supplies, food, drugs, and other professional supplies will be kept to the absolute minimum; purchase of these items will be on an as needed basis. The Developmental Disability Hospitals are expected to achieve reduced expenditures through consolidating the client's living spaces; continuing the hiring freeze that is currently in place; and reducing staff travel and supply purchases. KNI will continue to see reduction in expenditures through the consolidation of a home in FY 2009 and will start the consolidation of an additional home in 2010. Parsons will close Willow cottage in FY 2010 and consolidate these residents into another cottage.	There will be increased crowding of patients at KNI and Parsons as the homes and cottages are consolidated. This has historically resulted in an increased incidences of staff and patient injuries. The Mental Health Hospitals are operating at the bare minimum staffing to ensure active treatment and the safety of staff and patients. Further reductions of the MH hospital budgets would necessitate the need to cease voluntary admissions at the mental Health Hospitals and the closure of patient units. Current shrinkage rates at the Mental Health hospitals are running from 6.9 percent to 14.0 percent. Any further reductions, without reducing patient census, could put the hospital at risk of losing their license and certification.
Salaries and Wages			**FTE**		
Reduction in salary budget since the start of the FY 2009 Legislature	8,197,194	16,394,388	332	Field staff are handling more cases as SRS operates with considerably less staff.	The public may notice delays in some services due to overburdened staff.

Attachment C

Salaries

This dramatic rise in vacant positions has resulted in a rising caseload burden on regional staff. This is a leading agency concern, and the following graph illustrates the problem by displaying the caseload per position over time. The cases per position in October 2009 climbed to a new high of almost 270 cases per position. This is markedly higher than the 245 case per position norm (shown by the dotted line) which prevailed prior to the onset of the recession.

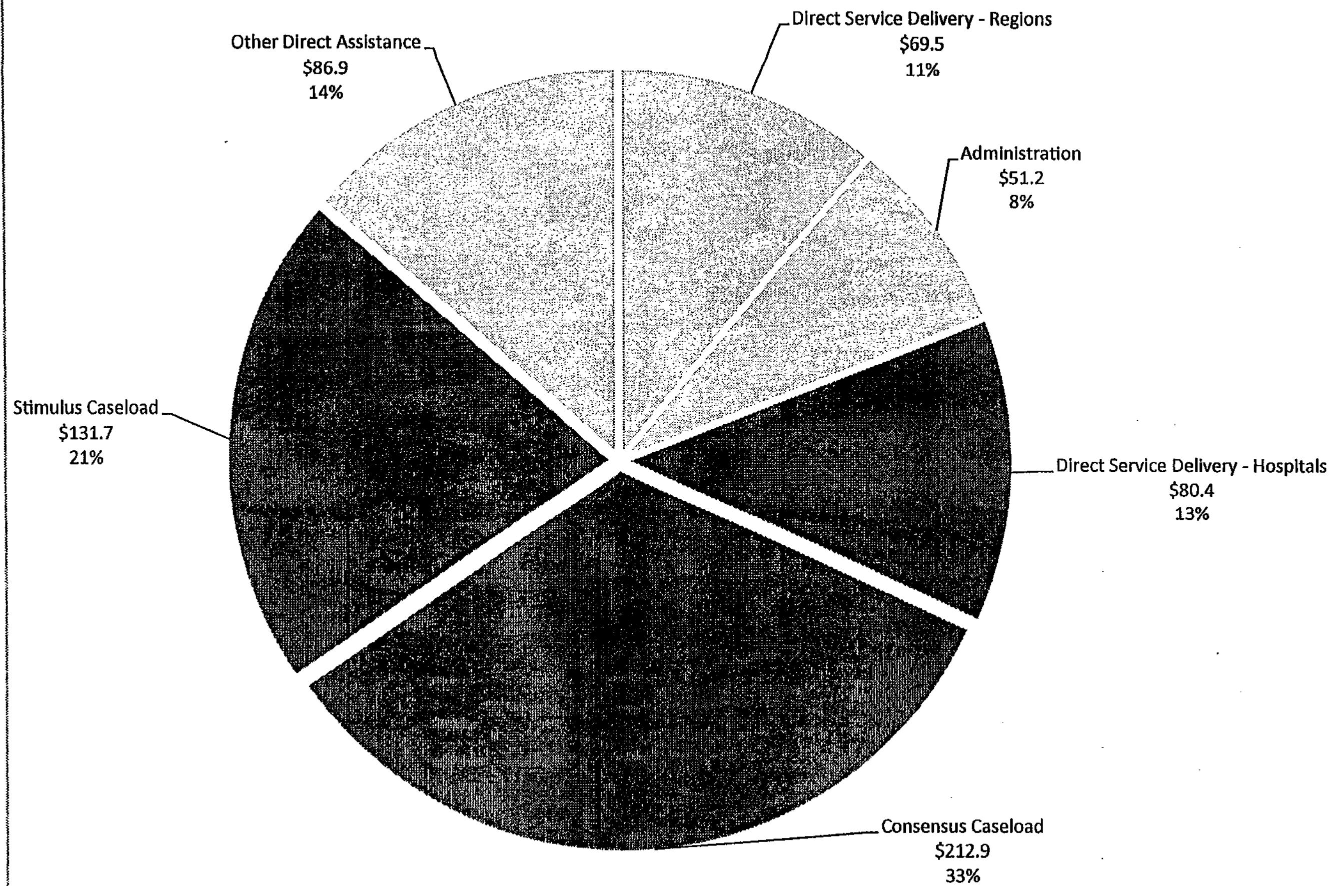


State Fiscal Year	Average Monthly Cases	Case-Carrying Positions	Cases per FTE
2001	288,332	1,264	228
2002	285,228	1,241	230
2003	280,303	1,223	229
2004	280,976	1,203	233
2005	286,835	1,202	239
2006	297,243	1,210	246
2007	298,126	1,214	246
2008	298,886	1,223	244
2009	305,435	1,212	252
2010 YTD	321,126	1,215	264
Most recent month:			
Oct 2009	322,705	1,203	268

The gap between the pre-recession 245 caseload norm and the current 268 cases per position demonstrates the tremendous caseload increase faced by regional staff. If the 245 staffing norm is applied to the total October 2009 caseload, 1,317 positions, or 114 more than the current count, would be required at a cost of approximately $5.9 million. However, this difference illustrates just the present staffing disparity. The caseload has not crested, and is estimated to reach 366,000 cases by the close of FY 2011. This corresponds to a 291 position increase at a cost of $14.9 million.

The department's responsibility is to process cases, investigate reports of child and adult abuse, adhere to federal performance standards, determine benefits and services appropriately, and provide case management. Sufficient staffing is required to meet these mission critical duties and ensure a human safety net is in place for the most vulnerable children, families and adults within our state.

Attachment D
FY 2010 SRS DOB Recommendations and Allotments including State Hospitals
SGF (in millions)



Key:
Lighter shade represents areas available for reductions.
Darker shade represents areas with budgetary restrictions.

Consensus programs:
- Temporary Assistance for Families
- General Assistance
- Community Support Services
- Mental Health Services
- Substance Abuse
- Foster Care/OOH

Stimulus programs:
- Medicaid Waivers
- Child Care
- Early Head Start

Other programs:
- Adoption Support
- Permanent Custodianship
- Grants

Total Budget $1,754.8
State General Funds $632.6
(numbers may not total due to rounding)

Presentation to Joint Committee on Health Policy Oversight

Effects of Governor's Allotments on the SFY 2010 KDHE Budget

Roderick Bremby, Secretary
Kansas Department of Health & Environment
December 17, 2009

KDHE

- 2010 approved budget - $230,708,415
- Legislature approved $32,170,759 in State General Funds for 2010 (13.94% of annual budget).
  - $553,355 below the Governor's recommendation.
  - 12.25% below the original SGF 2009 approved budget
- Governor's July allotment cut an additional $641,512.

Budget Action and Impact

Agency Operations

Action:

- Hiring freeze implemented in 10/2008.
- Abolished 79.0 vacant FTE positions.
- Accomplished with no layoffs of classified personnel.
- Terminated 2.0 unclassified positions.

Joint Health Policy Oversight
Date: 12/17/09
Attachment: 4

Budget Action and Impact

Impact

- Will affect agency's ability to respond to external requests, both legislative and administrative.
- Oral Health educational activities related to Maternal and Child Health programs will be eliminated.

Budget Action and Impact

Agency Operations

Action:

- In addition to estimated annual shrinkage, hold vacant 24.0 vacant FTE positions.
  - 6.0 FTE in Administration
  - 6.0 FTE in Division of Health
  - 12.0 FTE in Division of Environment

Budget Action and Impact

Impact

- Administration:
  - Triage administrative, legal, human resource, and fiscal responses and action.
- Health:
  - Reduction in Health Facility Program ability to conduct surveys of hospitals and new facilities seeking certification.

Budget Action and Impact

Impact

- Environment:
  - Agency is unable to hire a Laboratory Director, three senior laboratory management positions, and three technical laboratory positions.
  - Overall reduction in laboratory services.

Our Vision – Healthy Kansans living in safe and sustainable environments

Budget Action and Impact

Use Attainability Analysis, Stream Monitoring, Data Collection

Action:

- Eliminated or reduced state general funding for the Use Attainability Analysis (UAA), Stream Monitoring, and Data Collection

Our Vision – Healthy Kansans living in safe and sustainable environments

Budget Action and Impact

Impact

- UAA
  - Future UAA efforts limited to keeping findings current and up to date in accordance with existing and evolving state and federal requirements.
  - 5.0 unclassified positions will be eliminated in December, 2009, when federal funding is no longer available.

Our Vision – Healthy Kansans living in safe and sustainable environments

Budget Action and Impact

Impact

- Data Collection
  - 305(b) report mandated by EPA will be compiled by staff with no expertise.
  - Failure to produce report could result in sanctions by EPA against the state of Kansas.
  - Processing of constituent request for information will be difficult to provide and response time delayed.
  - ARRA funds being used to fund 3.0 FTE. If alternative funding not secured, program and 3.0 FTE will be eliminated by June, 2010.

Budget Action and Impact

Impact

- Stream Monitoring
  - Without stream monitoring, even more onerous to compile 305(b) report.
  - Short term federal funding being used to fund a portion of program.
    - If alternative funding is not secured, 2.5 FTE will also be eliminated by June 30, 2010.

Budget Action and Impact

Primary Care Health Program

Action:

- Decrease to the $855,000 contract with the Kansas Association of the Medically Underserved (KAMU) by $278,548, leaving $576,452.

Impact:

- No impact to agency administered grants to the safety net clinics.

Budget Action and Impact

Teen Pregnancy Case Management (TPCM)

Action:

- As a result of Governor's allotment, funding for this program was eliminated.

Impact:

- 270 teens enrolled in program as of 1/1/2009 will not be served.

Our Vision – Healthy Kansans living in safe and sustainable environments

Budget Action and Impact

Pregnancy Maintenance Initiative (PMI)

Action:

- As a result of Governor's allotment, funding for this program was eliminated.

Impact:

- The five service providers will most likely need to scale back services for approximately 478 clients.

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Budget Action and Impact

Meth Program

Action:

- As a result of Governor's allotment, funding for this program was reduced by $269,805, effectively eliminating the program.

Impact:

- KDHE will not respond to law enforcement requests to remove chemicals, assess for contamination, or assure residences are properly cleaned up.
- Responsibility falls to local agencies.

Our Vision – Healthy Kansans living in safe and sustainable environments

Budget Action and Impact

Governor's November Allotment

- State General Fund cut an additional $429,181

Budget Action and Impact

Additional Administration Shrinkage

Action:

- As a result of the Governor's allotment, shrinkage in Administration was increased by $49,041

Impact:

- KDHE will eliminate 1.0 FTE Public Health Educator in Administration

Budget Action and Impact

Infant Toddler Program

Action:

- As a result of the Governor's allotment, funding to the Infant Toddler program was cut by $183,573

Impact:

- Federal funding will be cut by $178,083 because of maintenance of effort requirements not met.
- ARRA funds will fill in the gap in 2010, but federal funding will not be restored in out years.

Budget Action and Impact

Coordinated School Health

Action:

- As a result of the Governor's allotment, funding to the Coordinated School Health program was cut by $46,567

Impact:

- Funding for the Program Manager position at KSDE for which KDHE contracts is eliminated. This will have a measurable and negative impact on the quality of service to grantees, impacting approximately 14,000 students.

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Budget Action and Impact

Vaccine Purchases

Action:

- As a result of the Governor's allotment, funding for vaccine purchases was cut by $50,000

Impact:

- Vaccine purchases will be reduced by 5.8 percent at a time when programs will be gearing up for pandemic influenza.

Our Vision – Healthy Kansans living in safe and sustainable environments

Budget Action and Impact

Laboratory

Action:

- As a result of the Governor's allotment, funding for the Laboratory was cut by $100,000

Impact:

- The efficiency in the Environmental Chemistry Lab will be reduced with respect to the analysis of both ambient and drinking water quality samples .

Our Vision – Healthy Kansans living in safe and sustainable environments

Budget Action and Impact

State Water Plan

Action:

- As a result of the Governor's allotment, State Water Plan funding was cut by $212,786

Impact:

- $122,786 was cut from the Contamination Remediation program, impacting the agency's emergency response.
- $40,000 was cut from the TMDL program.
- $50,000 was cut from the WRAPS program.

Contact Information

Susan Kang, J.D.
Kansas Department of Health and Environment
Assistant Secretary, Policy & External Affairs
skang@kdheks.gov or 785-296-0461

www.kdheks.gov

Joint Health Policy Oversight
Date: 12/17/09
Attachment: 5

Joint Committee on Health Policy Oversight

Dec. 17, 2009

Martin Kennedy, KDOA Acting Secretary

FY 2010 AND FY 2011 BUDGET ADJUSTMENTS

5

KDOA PROPOSED FY 2010 EXPENDITURES

Nursing Facility **$365.1**

Home and Community Based Services for Frail Elderly (HCBS/FE) **$71.9**

Program of All-inclusive Care for the Elderly (PACE) **$5.8**

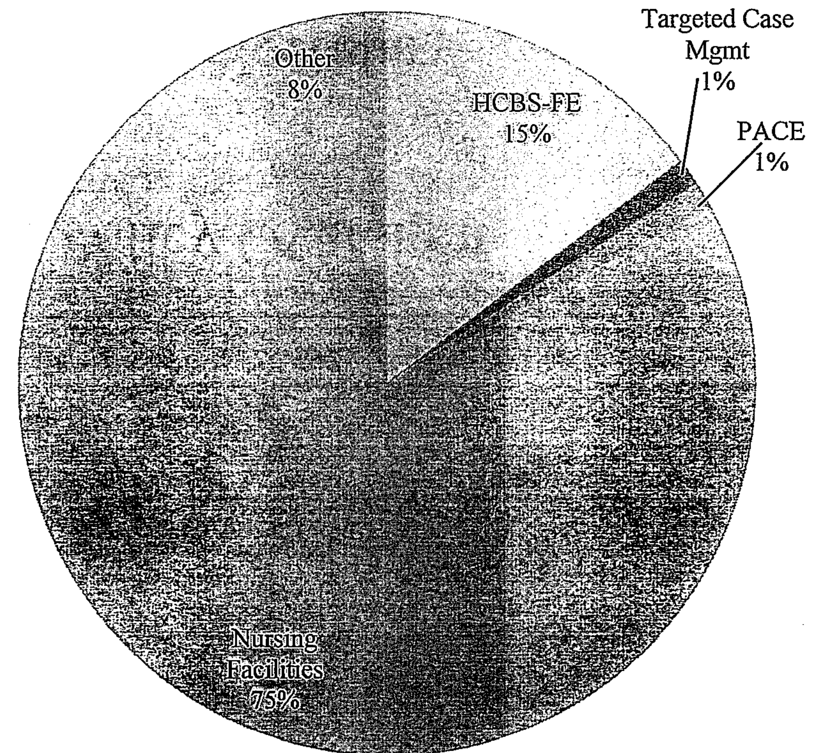
Targeted Case Management (TCM) **$5.8**

Other **$39.5**

- Congregate Meals
- Home Delivered Meals
- Older Americans Act (OAA)
- Senior Care Act (SCA)
- Licensure, Certification and Evaluation (LCE)
- Client, Assessment, Referral and Evaluation (CARE)
- SHICK & ADRC
- Administration

TOTAL **$488.1**

(Totals in millions)



SFY 2010 BUDGET ADJUSTMENTS

- Current state support for nutrition programs was not cut because ARRA funds provided $865,164 for nutrition programs over 2 years.
- The HCBS-FE waiver was funded at the 2009 level, which did not provide for case load growth.
- Nursing home rates were held flat.
- Senior Care Act funding was reduced $1.3 million ($829,048 for services; $484,110 for admin.)
- AAA core funding was suspended. ($750,000)
- Allotments reduced Medicaid reimbursements by 10% and required administrative cuts of $333,000 from SGF, along with a corresponding loss of federal matching funds.

SFY2010 10% MEDICAID PAYMENT REDUCTION

Medicaid Program-Total Funds	Pre-Allot. Caseload Budget	10% Reduction	Post Allot. Budget
Nursing Facility	$370,000,000	$9,250,000	$360,750,000
Home and Community Based Services-Frail Eldery (HCBS-FE)	71,561,929	1,789,048	69,772,881
Targeted Case Management-HCBS-FE	5,200,000	130,000	5,070,000
Program for All-Inclusive Care for the Elderly (PACE)	4,864,081	121,602	4,742,479
Total Medicaid Budget	**$451,626,010**	**$11,290,650**	**$440,335,360**
Medicaid Program-State General	**Pre-Allot. Caseload Budget**	**10% Reduction**	**Post Allot. Budget**
Nursing Facility	$112,424,500	$2,810,150	$109,614,350
Home and Community Based Services-Frail Eldery (HCBS-FE)	21,758,332	543,513	21,214,819
Targeted Case Management-HCBS-FE	1,580,020	39,494	1,540,526
Program for All-Inclusive Care for the Elderly (PACE)	1,477,951	36,943	1,441,008
Total Medicaid State General Fund	**$137,240,803**	**$3,430,100**	**$133,810,703**

FY 2011 BUDGET PLANNING

- The uncertainty of State revenues requires close scrutiny of programs on a month-by-month basis.
- HCBS-FE expenditures will be tracked carefully to avoid a waiting list. Some service reductions are anticipated to meet resource limitations.
- Operating costs will continue to be constrained, including holding vacant positions open. The first priority in operations is to maintain health and safety through adult care home surveys.

REDUCED RESOURCES

The Division of the Budget allocated KDOA a Reduced Resources target of 5% or $1,861,153 from its FY 2011 SGF Allocated Resources. Total all funds is $4,121,826.

- **Program for All-Inclusive Care for the Elderly (PACE)**

Reduce the state general fund (SGF) for the PACE program by $200,000 ($571,952 total funds). This will reduce the number of Medicaid eligible persons served by 30.

- **Senior Care Act (SCA)**

Reduce SGF for SCA direct services by $630,967. This represents a 30% reduction in the total SGF budget for direct services. It does not include a reduction in the federal Social Service Block Grant (SSBG) funds. The reduction will result in approximately 490 seniors no longer receiving SCA services during the year.

REDUCED RESOURCES

Home and Community Based Services-Frail Elderly (HCBS-FE) Rate Reduction

Reduce the SGF for the HCBS-FE program by $741,227 ($2,119,729 total funds). This represents a 3% rate reduction. This may result in the loss of service providers and less access to the HCBS-FE services.

Agency Operations

Reduce its SGF operations $288,959 ($799,178 all funds)

- Professional fees reduced $18,412 through negotiation with contractors to reduce fees and cutbacks on deliverables.
- 6.75% across the board reduction in travel.
- Shrinkage increased 4.06% for an agency-wide rate of 16.03%.
- Delay lifecycle capital information technology equipment replacement for another year.

SFY2011 10% MEDICAID PAYMENT REDUCTION

Medicaid Program-Total Funds (Millions)	Pre-Allot. Budget	10% Reduction	Post Allot. Budget	Caseload Adj.	Adj. Budget
Nursing Facility	$368,091,544	$37,370,000	$330,721,544	$5,608,456	$336,330,000
Home and Community Based Services-Frail Eldery (HCBS-FE)	70,657,621	7,065,762	63,591,859	-1,293	63,590,566
Targeted Case Management-HCBS-FE	5,201,293	520,000	4,681,293		4,681,293
Program for All-Inclusive Care for the Elderly (PACE)	5,743,526	574,353	5,169,173		5,169,173
Total Medicaid Budget	**$449,693,984**	**$45,530,115**	**$404,163,869**	**$5,607,163**	**$409,771,032**
Medicaid Program-SGF (Millions)	**Pre-Allot. Budget**	**10% Reduction**	**Post Allot. Budget**	**Caseload/FMAP Adjustment**	**Adj. Budget**
Nursing Facility	$128,714,251	$13,314,931	$115,399,320	$4,435,073	$119,834,393
Home and Community Based Services-Frail Eldery (HCBS-FE)	24,707,557	2,517,531	22,190,026	467,754	22,657,780
Targeted Case Management-HCBS-FE	1,818,788	185,276	1,633,512	33,972	1,667,484
Program for All-Inclusive Care for the Elderly (PACE)	2,008,396	204,642	1,803,754	38,022	1,841,776
Total Medicaid SGF	**$157,248,992**	**$16,222,380**	**$141,026,612**	**$4,974,821**	**$146,001,433**

DEPARTMENT OF HEALTH
AND ENVIRONMENT

Mark Parkinson, Governor
Roderick L. Bremby, Secretary

www.kdheks.gov

Testimony to
The Joint Committee on Health Policy Oversight
Presented By
Roderick L. Bremby, Secretary
Kansas Department of Health and Environment
December 17, 2009

Chairman Barnett and members of the committee I am Rod Bremby, Secretary of the Kansas Department of Health and Environment (KDHE). Thank you for inviting me this morning to discuss the State Health Information Exchange (HIE) initiative with you. I will be providing a high level overview of activities related to the State HIE for you, with much of the detail to be provided in the testimonies of Dr. Helen Connors, Mr. Larry Pitman, and Dr. Andy Allison, which you will hear later this afternoon.

In the spring of this year KDHE was assigned to be the state designee for health information technology, in this role KDHE is facilitating the creation of both strategic and operational plans for a statewide infrastructure for HIE. The discussion around the necessity of electronic health records (EHR) and HIEs has been taking place in Kansas for many years. This discussion has been reinvigorated by the inclusion of the Health Information for Economic and Clinical Health Act (HITECH) in the American Recovery and Reinvestment Act (ARRA) signed by President Obama in February 2009.

As part of HITECH there have been three funding streams identified to help in removing barriers to the implementation of EHRs and HIEs. HITECH provides for $643 million over the next four years for the establishment and operation of Regional Centers

CURTIS STATE OFFICE BUILDING, 1000 SW JACKSON S
Voice 785-296-0461 Fax 785

(RC). Our state has identified the Kansas Foundation for Medical care as the sole entity in the state to apply for funding as an RC in the first round of grants. HITECH also provides for $564 million in State HIE development. On October 16th KDHE applied to the Office of the National Coordinator for $9,066,010 of federal funds over the next four years to manage the planning and implementation of an HIE in the State of Kansas. Finally, HITECH provides for incentive payments to providers that can achieve meaningful use related to EHRs and HIEs prior to 2016. This funding is available through the Medicaid and Medicare programs directly to providers.

To enable the statewide interoperability of healthcare data, it is necessary to align a number of concurrent projects including the activities of KDHE, the Kansas Health Policy Authority (KHPA), KFMC, regional HIEs, and other interested parties through a coordinated approach. In response to this need and the need for expedited discussions concerning HIE in the state, KDHE re-convened the eHealth Advisory Council (eHAC). The eHAC is comprised of representatives from 33 health care related organizations around the state representing providers, hospitals, third-party payers, consumers, local health departments, small practices, academia, and public health. To date this group has met six times. It has helped in the production of the State HIE grant application and has begun to discuss the development of both a strategic plan and an operational plan as required by the grant. These plans will act as a blue print for the governance and structure of the HIE into the future

As a part of the eHAC there has been a steering committee created as well as five domain workgroups:

Governance- Helen Connors, PhD, RN

Finance- Robert St. Peter, MD

Technical Infrastructure- Brad Williams

Business and Technical Operations- Michael Kennedy, MD

Legal/Policy – Jeff Ellis

The steering committee includes the domain chairs from each of the eHAC workgroups, as well as representatives from the KHPA, KFMC, and a Quality Improvement Consortium.

As the state designated entity on HIE, KDHE plans to continue to be heavily involved in planning and implementation discussions with the KHPA and the KFMC as the future of HIE in Kansas continues to develop. For additional information on the HIE Initiative please visit our project website at www.KanHIT.org. Thank you for your time this morning, and I would be happy to stand for questions.

Joint Committee on Health Policy Oversight

Update on Statewide Health Information Exchange

December 17, 2009

Helen Connors, PhD, RN

Chairman Barnett and members of the committee, thank you for inviting me to provide testimony on behalf of the Kansas e Health Advisory Council (eHAC). My name is Helen Connors. I am a professor at the University of Kansas, School of Nursing and Executive Director for the University of Kansas Center for Health Informatics. Currently, I chair the Kansas e Health Advisory Council.

The eHAC was originally established by Governor Sebelius's office through KHPA in 2008. It was established to guide the continued development of Kansas E-Health initiatives based on the final recommendations of the Health Information Technology/Health Information Exchange Policy Initiative, the Kansas Health Information Exchange Commission, and the Health Information Security and Privacy Collaborative (HISPC). However, the 2009 Legislature did not fund any of the agency's enhancement requests as recommended by the Governor. With multiple new funding opportunities through the American Recovery and Reinvestment Act (ARRA), in July 2009, Governor Parkinson appointed Kansas Department of Health and Environment as the state designated entity for Health Information Technology (HIT) and named Secretary Bremby as the HIT Coordinator for Kansas. The re-envisioned e-Health Advisory Council includes representatives from thirty-three different healthcare-related organizations across Kansas; including KDHE – the State's designated HIT/HIE agency, and Kansas Health Policy Authority (KHPA) – the State's designated Medicaid entity (see attachment for a list of the Council members).

Joint Health Policy Oversight
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The purpose of the eHAC is to:

1. Advise the Secretary of KDHE on the development of strategic and operational plans for a state-level implementation of HIE;

2. Advise and identify points of coordination regarding related HIT activities, including but not limited to workforce development, broadband planning, coordination with Medicaid planning, development of the Regional Center, Chronic Care initiatives, etc.; and

3. Listen to and represent the interests of a broad group of HIE stakeholders as Kansas moves toward a State-Level HIE effort.

Since August 2009, the eHAC has met monthly and will continue to meet monthly as long as necessary to develop and implement the Kansas HIT Strategic and Operational Plans. The eHAC is supported by five domain work groups essential to the project. State-level HIE's are required by the ONC to plan, implement and evaluate activities across all five of these domains. A brief description of the five work groups and their chairpersons are listed below:

1. **Governance** – Helen Connors, PhD, RN

This domain addresses the functions of convening health care stakeholders to create trust and consensus on an approach for statewide HIE and to provide oversight and accountability of HIE to protect the public interest. One of the primary purposes of a governance entity is to develop and maintain a multi-stakeholder process to ensure HIT/HIE among providers is in compliance with applicable policies and laws.

2. **Finance** - Robert St. Peter, MD

This domain encompasses the identification and management of financial resources necessary to fund health information exchange. This domain includes public and private financing for building HIE capacity and sustainability. This also includes but is not limited to pricing

strategies, market research, public and private financing strategies, financial reporting, business planning, audits, and controls.

3. **Technical Infrastructure** – – Brad Williams

This domain includes the architecture, hardware, software, applications, network configurations and other technological aspects that physically enable the technical services for HIT/HIE in a secure and appropriate manner.

4. **Business and Technical Operations** – Michael Kennedy, MD

The activities in this domain include but are not limited to procurement, identifying requirements, process design, functionality development, project management, help desk, systems maintenance, change control, program evaluation, and reporting. Some of these activities and processes are the responsibility of the entity or entities that are implementing the technical services needed for health information exchange; there may be different models for distributing operational responsibilities. One model that is specifically being addressed is the Patient Centered Medical Home concept.

5. **Legal/Policy** – Jeff Ellis

The mechanisms and structures in this domain address legal and policy barriers and enablers related to the electronic use and exchange of health information. These mechanisms and structures include but are not limited to: policy frameworks, privacy and security requirements for system development and use, data sharing agreements, laws, regulations, and multi-state policy harmonization activities. The primary purpose of the legal/policy domain is to create a common set of rules to enable inter-organizational and eventually interstate health information exchange while protecting consumer interests.

Each work group consists of 10–15 members (legal Work Group – 26 healthcare lawyers) and has its own charter with specific purpose, charges, deliverables, and evaluation criteria. Members of the eHAC serve on at least one of these work groups as prescribed by the ONC. Other interested strategic stakeholders also are members. Work groups will meet monthly through the strategic and operational planning process.

The five chairpersons and four at-large members make up the eHAC steering committee. The steering committee meets monthly approximately one week before the Council meeting.

KDHE and eHAC are supported by an eHealth Consultant team consisting of HIT/HIE content experts as well as process experts. The consultant team keeps the eHAC informed on HIT/HIE issues and facilitates the meeting process. (see attached organizational chart)

Work of the eHAC

Since August, the eHAC has met six times as has the steering committee. The work has primarily focused on: educating and organizing the eHAC and work groups; beginning the work as outlined in the respective charters; applying for various funding opportunities made available through ARRA; and assessing the current state of health information exchanges in Kansas and the Kansas City Area to be sure to accommodate early adopters in the statewide effort and avoid duplication of resources.

Proposals Submitted

- **State Regional Centers**
  - Purpose – To become a Regional Health Information Technology Center (RC) for the State. The RC will offer technical assistance, guidance and information on best practices to support and accelerate health care provider's efforts to become meaningful users of EHRs. The RC will focus their most intensive technical

assistance on clinicians furnishing primary care services, with particular emphasis on individual and small group practices as well as clinicians providing primary care in public and critical access hospitals, community health centers, and other settings that predominately serve uninsured, underinsured and medically underserved populations.

- Lead Organization – Kansas Foundation for Medical Care, Inc. – (Larry Pitman)
- Key Strategic Partners - Over 1200 clinicians/providers in Kansas have requested support services.
- Funding request – approximately $9 million over four years. Preliminary application submitted 09/08/09. Full proposal submitted 10/30/09. Funding notification 01/21/10. If necessary, resubmission 01/05/10.

- **State HIE Cooperative Agreement Program**
  - Purpose – To support the State Designated Entity (KDHE) to develop the infrastructure to achieve widespread and sustainable statewide Health Information Exchange within and among states through the meaningful use of certifies EHRs. The State HIE Cooperative Agreement Program funds efforts at the state level to establish and implement appropriate governance, policies and network services within the broad national framework to rapidly build capacity for connectivity between and among healthcare providers.
  - Lead Organization – KDHE, the State Designated Entity (SDE) – Aaron Dunkel
  - Key Strategic Partners – KHPA, the eHAC, Work Groups and Consultant team
  - Funding Request- $10 Million. Proposal submitted 10/16/09. Funding notification date 01/15/10

Potential Proposals

- **Community College Consortia to Educate Health IT Workforce**
- **Curriculum Development Centers**
- **Beacon Community Cooperative Agreement Program**
- **Chronic Disease grant**
    - Purpose – To expand the current Chronic Disease Electronic Management System to include tracking more diseases, increased clinician access, increased patient engagement, bi-directional web-based interfaces and a personal health record.
    - Lead organization – KDHE
    - Key Strategic Partners - Providers who mange Chronic Disease and patients with Chronic Disease.
    - Funding request – $2.8 Mil over 2 years through a TBD federal grant.

Challenges

- **Culture Change –** This is a huge cultural shift within healthcare.
- **Early adopter versus laggards –** Rapid Deployment Team (Skunk Works) to capture momentum of the early adopters while strategically and operationally planning to accommodate all health providers across the state.
- **Technical Infrastructure –** The need for Broadband in Rural America is becoming more critical with HIE. Common problems affecting rural broadband, include connectivity issues, technological challenges, and high network costs.
- **Sustainability-** Long term sustainability needs to be addressed up-front.

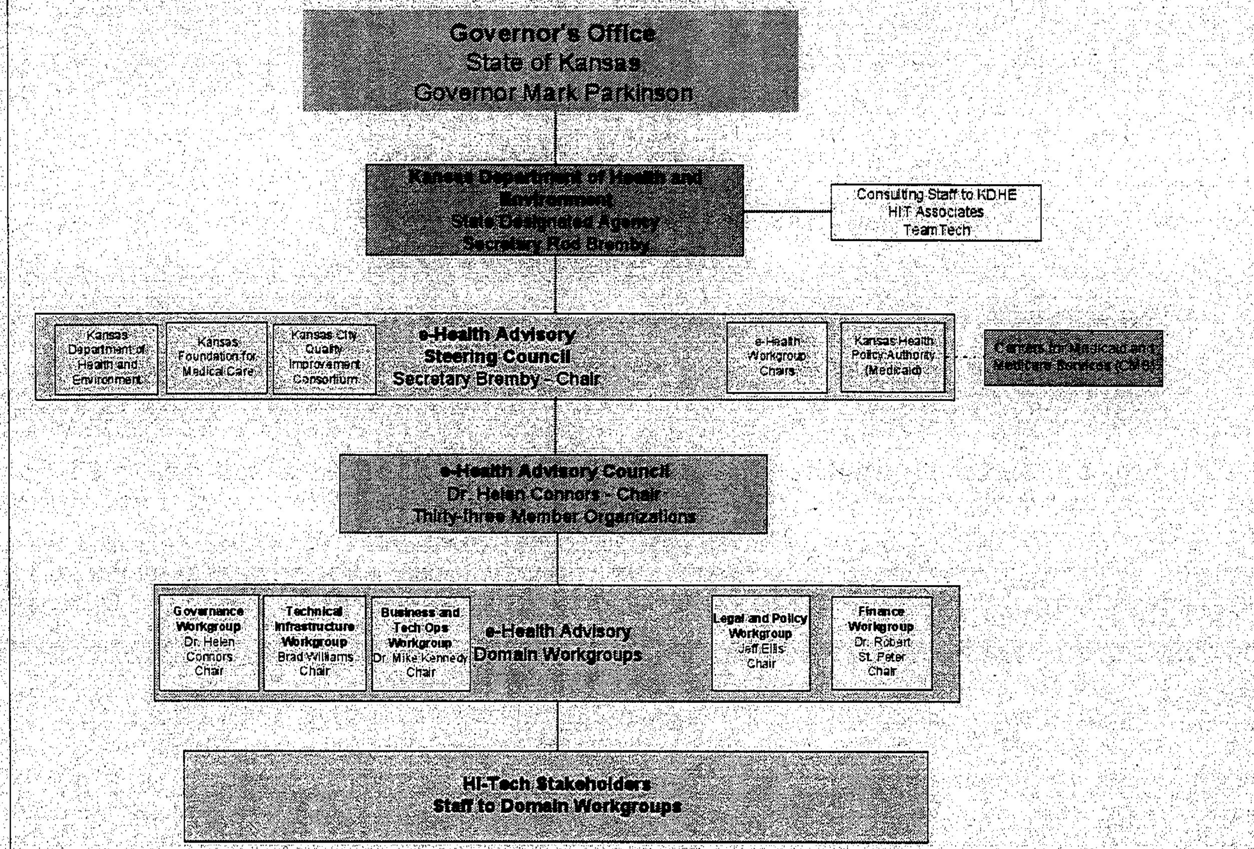
- **Statutory and Policy Revision** - Statutory and policy revisions are essential to remove barriers and promote adoption of HIT/HIE. Laws need to be harmonized both internally and with federal laws. The legal work group will propose statutory revisions to promote statewide and intrastate HIE that assure privacy and security and protect providers and patients who participate in HIE.

Summary – In summary, there is a great deal of work to be done; however, the structure is in place to get it done. As you can see from the list of participants involved there is a wide variety of stakeholders who stand ready to get it done now and get it done right.

For more information regarding the work of the eHAC, visit www.KanHIT.org.

e-Health Advisory Council Members

Name	**Association**
Amy Campbell	Kansas Mental Health Coalition
Dr. Andy Allison	Kansas Health Policy Authority
Bill Bruning	Mid-America Coalition on Health Care
Brad Williams	KanEd
Brett Klausman	Midwest Health Management
Cathy Davis	KC Quality Improvement Coalition
Dan Elliott	Kansas Association for the Medically Underserved
Claudia Blackburn	Sedgwick County Public Health Department
Corrie Edwards	Kansas Health Comsumer Coalition
Dennis Lauver	Salina Area Chamber of Commerce
Gary Caruthers	Kansas Medical Society
Helen Connors (chair)	University of Kansas Center for Health Informatics
Jacqueline John	Great Plains Health Alliance
Jeff Ellis	Lathrop & Gage
Dr. Jennifer Brull	Prairie Star Family Practice
Jimmy Brown	Swope Health Services
Jon Rosell	Sedgwick County Medical Society
Karen Braman	Preferred Health Systems
Kevin Sparks	Blue Cross Blue Shield of Kansas City
Larry Pitman	Kansas Foundation for Medical Care
Lynda Farwell	Cotton O'Neil Clinic
Maren Turner	Kansas AARP
Marta Linenberger	Foulston Siefkin
Melissa Hungerford	Kansas Hospital Association
Michael Atwood	Blue Cross Blue Shield of Kansas
Dr. Michael Kennedy	Medical Homes Initiative
Mike Fox	KU Researcher
Dr. Robert St. Peter	Kansas Health Institute
Roderick Bremby	Kansas Department of Health and Environment
Ryan Spaulding	KUMC
Sandy Praeger	Kansas Insurance Commissioner



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JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT
UPDATE ON STATEWIDE HEALTH INFORMATION EXCHANGE
OFFICE OF NATIONAL COORDINATOR (ONC)
AND REGIONAL CENTER DESIGNATION

PRESENTED BY
LARRY W. PITMAN, PRESIDENT AND CEO
KANSAS FOUNDATION FOR MEDICAL CARE, INC

DECEMBER 17, 2009

Good afternoon Mr. Chair and members of the committee. I am Larry Pitman, President and CEO of the Kansas Foundation for Medical Care, Inc. I will be updating you on another segment of the ARRA stimulus package calling for the establishment of approximately 70 Regional Centers throughout the country. We anticipate Kansas will be designated a statewide Regional Center.

The American Recovery and Reinvestment Act (ARRA) stimulus package includes financial incentives for health care providers that attain "meaningful use" with their electronic health record (EHR) systems. It also supports the creation of Health Information Technology Regional Extension Centers. These centers will support physician practices in adopting EHR systems and improving use of current systems to achieve meaningful use criteria and obtain the incentives.

The Kansas Foundation for Medical Care, Inc., (KFMC), a private, non-profit community based organization dedicated to facilitating the improvement of healthcare in Kansas was invited to submit a full proposal to the Office of the National Coordinator for Health Information Technology to serve as the Regional Extension Center for Kansas. If awarded, KFMC will provide expert technical support, subsidized by federal funds to over 1,200 primary care providers who are interested in adopting EHR's or using existing systems to achieve the meaningful use incentives.

What are the Incentives?
Beginning with professional services provided in 2011, physicians who adopt and use electronic health records to improve care may be entitled to:

Medicare: Up to $44,000 per provider, over five years
Medicaid: Up to $63,750 per provider, over six years

How to Earn Incentives?
To be eligible for incentives a provider must:

1. Use a certified EHR in a "meaningful" manner;
2. Exchange health information to improve the quality of care (through a health information exchange, if available); and
3. Report on quality measures.

This must be achieved by 2015 or Medicare disincentives will begin. Those who succeed by 2011 will earn the largest incentives.

Who Can Receive Assistance?

1. **Primary Care Practices** include: Family Practice, Internal Medicine, OB/GYN, and Pediatrics.
2. **Community & Rural Health Centers** that predominately serve the uninsured and underinsured.

Non-priority practices such as specialty clinics can receive unsubsidized assistance from the Regional Centers. Higher fees would cover the cost of the services provided.

Why KFMC?

As a community-based non-profit organization, KFMC is vendor-neutral, has been working with health professionals in Kansas for decades to improve quality of care, and has already helped over 200 Kansas practices adopt and more effectively use EHRs. We are a known and trusted entity in the state.

What \ .ie Project Entail?

KFMC will work on a four- year project from 1/15/10 to 1/15/13, providing direct clinical and technical assistance to primary-care providers in Kansas as they implement Health Information Technology. KFMC will work in collaboration with the Kansas Department of Health and Environment, its eHealth Advisory Council, and the Council membership, comprised of representatives of major healthcare stakeholders in Kansas, and additional healthcare partners to maximize the services and reach of the Kansas Regional Center (RC) program to meet the Office of the National Coordinator's goals.

KFMC will provide direct technical assistance to1200 primary care providers across the state, focusing on those that are in small group practices that provide care to the medically underserved, underinsured, and uninsured. Services provided through the KFMC RC Program include direct on-site assistance to complete Electronic Health Record (EHR) practice readiness assessments, practice work-flow assessments and redesign, certified EHR vendor evaluation and selection with a group purchasing discount, EHR implementation, assistance with meeting the criteria for meaningful use, reporting of clinical quality measures, and connectivity to a Health Information Exchange (HIE). Although Kansas is a largely rural state, with 86% of the 105 counties either frontier, rural, or densely populated rural, KFMC has broad experience in providing EHR implementation support not only in rural settings, but urban and bi-state areas as well. Effective approaches to provide efficient and responsive services will include use of regionally assigned technical and clinical experts, availability of a variety of distance learning tools, and interventions tailored to the unique needs of the special populations served in the rural communities.

Short term program goals include:

- Assisting 1200 priority primary-care providers across Kansas to implement a certified EHR, become meaningful users, and participate in a HIE.
- Development of a coordinated state-wide effort that includes a governance structure that is collaborative and doesn't duplicate services or funded activities.
- Maximizing provider reach with available funding to minimize financial burden on priority providers.
- Assisting in the development and use of standards and best practices to ensure information privacy and security.
- Providing efficient, effective, useful resources to accelerate the providers' capacity to implement a certified EHR and move to meaningful use.

Long term program goals include:

- Development of a sustainable future infrastructure for a Regional Center in KS beyond HHS funding.
- Assisting in the establishment of statewide standards for HIT for Kansas providers. Establishment of meaningful use of Kansas providers to improve healthcare collaboration among providers and increase positive patient outcomes.
- Establishment of a method to allow Kansas consumers reasonable access to electronic personal health record information.

Thank you, I would be happy to answer any questions you have.

Larry W. Pitman
President and CEO
Kansas Foundation for Medical Care, Inc.
2947 SW Wanamaker Drive
Topeka, KS 66614-4193
(785)273-2552
lpitman@kfmc.org

HealthWave Update from the Kansas Health Policy Authority

Testimony to the Joint Committee on Health Policy Oversight
December 17, 2009

Dr. Andrew Allison, KHPA Acting Executive Director

HealthWave

- Managed Care is designed to create financial incentives for private health plans to provide access to appropriate care and to improve health outcomes while eliminating unnecessary services through administrative control
- 62% of all covered lives for Medicaid and CHIP received care through a Physical Health MCO
- 173,462 HealthWave members in November 2009

HealthWave

- Kansas has contracted with a number of Managed Care Organizations since 1995 to provide Medicaid and CHIP services
- Contracts are let through a competitive bidding process, last completed in 2006
- Current contractors include:
  - Physical Health
    - Children's Mercy Family Health Partners
    - UniCare Health Plan of Kansas
  - Mental Health/Substance Abuse
    - Cenpatico Behavioral Health

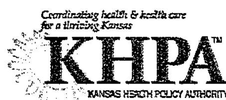
HealthWave

- HealthWave had an annual expenditure of $383,645,169* in SFY 09
  - 29% of the KHPA service budget
  - 15% of the Medicaid service budget for all agencies

*Figures obtained from the 2009 MAR report

HealthWave

- Features:
  - **Risk Based Contracting.** Plans are paid a fixed amount in advance to cover both provider reimbursements and administrative costs (may include profit). This transfers financial risk to the plan and is intended to incentivize cost-effective management of health care services
  - **Access.** Improved access to PCP and Specialty providers for all members??
  - **Care Management.** MCOs offer disease management, care management, coordination of care, and educational programs to a select group of members.
  - **Quality.** Care provided to members is measured, monitored and quality improvement projects are implemented.
  - **Costs.** Program costs are determined through competitive rate setting. The bidding process subjects Medicaid to more of a market-based transaction with providers. KHPA is reviewing the net impact on costs to the state.
  - **Reducing Stigma.** Anecdotally, members accept care more readily and develop a better understanding of the medical care landscape as they transition away from assistance programs.



HealthWave Data

- HealthWave MCOs provide a number of reports for contract monitoring, plan comparison, and program development. These include:
  - **Quality metrics.** CAHPS, Provider Satisfaction Survey, & HEDIS
  - **Service Utilization.** ER/Hospital, Blood-Lead Testing, KBH, and Pharmacy Utilization Reports
  - **Financial.** Quarterly Income and Expense Reports

HealthWave Data

- CAHPS Survey (Consumer Assessment of Healthcare Provider & System)
  - Nationally recognized tool for measuring the satisfaction of members with their healthcare and health plan.
  - CAHPS are completed for both MCOs and HealthConnect Kansas
  - Results are compared to both regional and national benchmarks.

HealthWave Data

The HealthWave general child populations were more satisfied than Midwest Region and National populations on all measurements, including the following examples:

- Getting a personal doctor or nurse you are happy with
- Getting the care, tests, or treatment you or your doctor believed necessary
- Getting an appointment as soon as you wanted, when care was not needed right away
- Getting the help needed when calling the health plan's customer service
- Rating of personal doctor
- Rating of specialist seen most often
- Rating of health plan

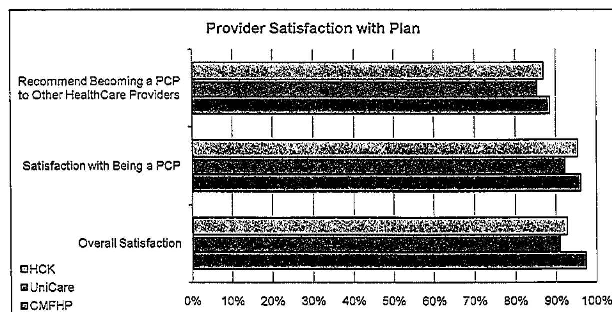
HealthWave Data

The HealthWave Adult populations were in line with regional and national benchmarks, except for the following:

- Plan Customer Service ranked higher than regional and national benchmarks
- 5 measures below regional and national marks:
  - Doctors explaining things in an easily understood way
  - Doctors listening carefully to you
  - Doctors Showing respect for what you had to say
  - Doctors Spending enough time
  - Rating of the specialist seen most often

HealthWave Data

- The Kansas Foundation for Medical Care, KFMC, was contracted to field a provider satisfaction survey aimed at primary care providers participating in the UniCare, CMFHP, and HealthConnect Networks.



HealthWave Data

HEDIS – Healthcare Effectiveness Data and Information Set

- An instrument used by more than 90 percent of health plans in the United States to measure performance on important dimensions of care and service.
- MCOs annually submit outcomes of their HEDIS performance measures for review.
- Reports are stratified for Medicaid, CHIP, and for Children with Special Health Care Needs.

HealthWave Data

- KHPA requires MCOs to collect data on the following HEDIS measures:
  - Adult access to preventive/ambulatory health services.
  - Comprehensive diabetes care (HbA1c tests).
  - Prenatal and postpartum care (prenatal visits).
  - Antibiotic Utilization.
  - Children's access to primary care practitioners.
  - Use of appropriate medications for children with asthma.
  - Well-child visits in the first 15 months of life.
  - Well-child visits in the 3rd, 4th, 5th, and 6th year of life.
  - Lead Screening in Children.

HealthWave Data

- Areas for improvement have been identified through the use of the above mentioned quality metrics, and incorporated into Performance Improvement Projects.
  - HEDIS Comprehensive Diabetes Care results were significantly below national standards.
  - CMFHP and UniCare are collaborating in a joint performance improvement project to improve Diabetes Care across both plans, initial results in spring of 2010 and follow-up review in 2011.
  - CMFHP will be trying to improve the Chlamydia Screening Rates with the Spring 2010 PIP
  - UniCare will be trying to improve beneficiary knowledge of transportation and provider knowledge of translation services to improve the health care experience of members

HealthWave Data

- In early 2009, KHPA began to share quality data publically by placing reports on the KHPA website
  - www.khpa.ks.gov/quality_reports/healthwave.html
  - Executive summaries are available for CAHPS, HEDIS, and Provider Satisfaction results.
  - Complete reports can be requested.

HealthWave Data

- What data improvements can be made?
  - Pending improvements in data systems will dramatically enhance our ability to review MCO performance and enable comparisons of the HealthWave population to Medicaid fee for service, the state employee health plan, and the private insurance market

HealthWave Rates

- HealthWave MCOs are reimbursed through a full risk pm/pm capitation.
- CMS requires that an Actuarial Firm develops these rates, taking into account the list of covered services, FFS utilization patterns, and managed care efficiencies.
  - SFY 2009 rates
    - 1.7% decrease in HW 19 (est. $4 million shift)
    - 1.2% increase in HW 21
    - Rebasing with adjustment for the prior over estimate of the effect of provider assessment
  - SFY 2010 rates
    - 1.3% increase in HW 19
    - 1.2% increase in HW 21
    - 2% admin allotment decrease across rates for both HW 19 & 21

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

- Reauthorized and funded CHIP through 2013, allowing for continued funding
  - Allowing Kansas expansion to 241% of poverty
- Allowed for states to request bonus payments if a number of metrics were achieved
  - Kansas conditionally approved
- Required multiple options for members allowing for disenrollment to a second coverage option
  - Will require either a second MCO in the western 1/3 of Kansas or statutory change to allow SCHIP recipients to choose the KHPA fee-for-service alternative

CHIPRA

- Required Mental Health Parity for CHIP
  - will necessitate a state plan change and an increase in Mental Health expenditures for CHIP members
- Required External Quality Review Organization (EQRO) involvement for CHIP MCOs
  - necessitating an increase in expenditure to cover CBH
- Required Citizenship and Identity verification for all CHIP applicants
  - adds to the difficulties and delays at our Clearinghouse
- Taking advantage of options to streamline eligibility determinations allowed by CHIPRA

Ongoing issues

Efforts in 2010:

- Create new coverage option in the western 1/3 of Kansas.
- Adjust Mental Health benefit for CHIP members
- Ensure smooth process for the expansion of CHIP
- Closely monitor Performance Improvement Projects (PIPs) and assess the level to which improvement occurs; identify and enact appropriate measures for addressing lack of improvement or progress.
- Assess the net impact of MCOs on state expenditures.
  - KHPA Board has requested an analysis of consolidating HealthWave claims payment and care management into the Medicaid fee-for-service operation