MINUTES

JOINT COMMITTEE ON HOME AND COMMUNITY BASED SERVICES OVERSIGHT

November 8, 2010
Room 548-S—Statehouse

Members Present

Representative Bob Bethell, Chairperson
Senator Laura Kelly
Senator Kelly Kultala
Representative Jerry Henry
Representative Peggy Mast
Representative Melody McCray-Miller (appearing by phone)

Members Absent

Senator Carolyn McGinn, Vice-chairperson
Senator Dwayne Umbarger
Representative Brenda Landwehr

Staff Present

Kathie Sparks, Kansas Legislative Research Department
Amy Deckard, Kansas Legislative Research Department
Iraida Orr, Kansas Legislative Research Department
Doug Taylor, Office of the Revisor of Statutes
Jackie Lunn, Committee Secretary

Conferees

Gerald Sloan, Vice-president, Midwest Association for Medical Equipment
Kim Gustafson, Interim Executive Director, Health-E-Quip, Hutchinson, Kansas
Jane Kelly, Executive Director, Kansas Home Care Association
Sara H. Sack, PhD., Assistive Technology for Kansans
David Kemp, OTR/L, ATP, Vice-president, Technical Services, Carney Rehab Engineering Center, Cerebral Palsy Research Foundation of Kansas, Inc., Wichita, Kansas
Kevin Robertson, Executive Director and CAE, Kansas Dental Association
Maggie Smet, RDH, President, Kansas Dental Hygienists' Association
Doreen Eyler, Extended Care Permit, Grace Med, Wichita, Kansas
Tanya Dorf Brunner, Executive Director, Oral Health Kansas
Dr. Andy Tompkins, Board President and CEO, State Board of Regents
Ray Dalton, Deputy Secretary, Kansas Department of Social and Rehabilitation Services

Martin Kennedy, Secretary, Kansas Department on Aging
Bill McDaniel, Program and Policy Commissioner, Kansas Department on Aging
Scott Brunner, Chief Fiscal Officer, Kansas Health Policy Authority

Morning Session

Chairman Bethell called the meeting to order at 10:10 a.m. and welcomed those in attendance. The Committee's attention was turned to the charge given to the Committee as detailed in the handout entitled *2010 Joint Committee on Home and Community Based Services Oversight* (Attachment 1). Chairman asked the Committee to consider the recommendations they would make before today's adjournment.

Gerald Sloan, Vice-president, Midwest Association for Medical Equipment Services, provided a power-point presentation on the effect of Medicare's Competitive Bidding Program on Access to Durable Medical Equipment. Mr. Sloan presented written copy of the power-point presentation (Attachment 2). He stated the National Competitive Bidding System will go into effect in January 2011. He explained that, at the present time, Medicare patients can buy from any qualified provider and may switch providers if they are not satisfied with the quality of care they are receiving. Under the new government program called Competitive Bidding, Medicare patients will not be able to receive services from any durable medical equipment provider of their choosing. Medicare will be taking bids from providers and will choose the lowest bidder. These chosen providers will furnish goods and services to Medicare patients. Mr. Sloan voiced the concerns of several home health care providers regarding the National Competitive Bidding program. These concerns included small providers feeling pressured to accept economically unsustainable bids in order to receive a contract, decreased access to local providers in rural areas, and the inability of bid-winning out-of-state providers to provide immediate care. A question and answer session followed.

Kim Gustafson, Interim Executive Director, Health-E-Quip located in Hutchinson, Kansas presented her testimony regarding the effect of Medicare's Competitive Bidding Program. Ms. Gustafson provided written copy of her testimony (Attachment 3). She stated the bidding program will restrict consumer access to care and choice for home medical items and services; will trigger a race to the bottom in terms of quality; and will also increase Medicare costs by leading to longer, more expensive hospital stays and more emergency room visits. Ms. Gustafson indicated the bidding program is anti-competitive because it reduces the number of competitors which will result in the closing of thousands of small businesses and in as many as 100,000 job losses nationwide. In closing, she urged the Committee to contact their representatives in Washington asking them not to support the Competitive Bidding Program. A question and answer session followed.

Chairman Bethell recognized Jane Kelly, Executive Director, Kansas Home Care Association to provide her testimony regarding the effect of the CMS Competitive Bidding Program on Durable Medical Equipment on access for our elderly, disabled and chronically ill population. Ms. Kelly presented written copy of her testimony (Attachment 4). She opened by explaining durable medical equipment (DME) refers to a class of medical supplies. These supplies are reusable, used in the home, and used to help an illness or a symptom of an illness. Examples would include scooters, hospital beds and prosthetics. The Competitive Bidding Program was mandated by Congress through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Ms. Kelly indicated the Competitive Bidding Program would lower quality, reduce access to care, and reduce competition by eliminating up to 90 percent of home health equipment businesses in any market area where the program is implemented. She stated competitive bidding would ignore the critical role of services required to provide care to people in their homes, and does not adequately

account for the providers' ability to serve a geographic market. Ms. Kelly further stated the result of provider competition based on price, rather than the quality of supplies or customer service, may result in significant reductions to the quality of items and services beneficiaries need to remain at home, independently. Ms. Kelly stated this program is not the solution to Medicare's reform, and it is certainly not the answer for patients and seniors. In closing, she urged the Committee not to support this program. A question and answer session followed.

Sara H. Sack, PhD, Assistive Technology for Kansans, testified regarding the CMS Competitive Bidding Program for Durable Medical Equipment. Dr. Sack presented written copy of her testimony (Attachment 5). Assistive Technology for Kansans has the following bidding program concerns:

- Durable medical equipment suppliers, especially small businesses, will be going out of business;
- Loss of small businesses and employment opportunities in Kansas will be devastating to communities and the consumers;
- The economic saving from competitive bidding may not be as forecasted;
- Loss of durable medical equipment supplies is bad for consumers;
- A longer waiting period for equipment and repairs puts Kansans at medical risk;
- Lack of access to durable medical equipment negatively impacts a person's ability to live independently;
- Proposed savings from the competitive bidding process, especially for this population of persons with disabilities and significant health conditions, may in fact result in increased costs for other programs due to increased medical and care costs;
- The competitive bidding process, as designed, does not protect beneficiaries against difficulties in accessing equipment and necessary services;
- There is no requirement for response time, i.e, delivery time;
- Reducing the choice of suppliers jeopardizes the lifelong relationships often established with suppliers and technicians who are familiar with the specific needs and care of persons with significant disabilities and health conditions;
- Choice, in terms of suppliers and equipment, will be limited;
- Durable medical equipment is not a "one size fits all" type commodity that is easily interchangeable and is often customized to fit the individual which further necessitates the need for a range of equipment and options; and
- Prior to competitive bidding, consumers may have obtained all necessary services from a single supplier. Under competitive bidding, consumers may have to visit several suppliers in order to meet their needs, thereby increasing the time, expense, and transportation barriers.

In closing, Dr. Sack stated while Assistive Technology for Kansans applauds efforts to use healthcare dollars wisely, competitive bidding for durable medical equipment and services does not seem to be the recommended strategy, as the potential negative impact is too great.

Chairman Bethell recognized David Kemp, OTR/L, ATP, Vice-president of Technical Services, Carney Rehab Engineering Center, Cerebral Palsy Research Foundation of Kansas, Inc., located in Wichita, Kansas, to provide his testimony on the CMS Competitive Bidding Program for Durable Medical Equipment. Mr. Kemp presented written copy of his testimony (Attachment 6). He stated that Technical Services at the Daniel M. Carney Rehabilitation Engineering Center, which is a division of the Cerebral Palsy Research Foundation (CPRF), has many concerns regarding the competitive bidding program. Last year, CPRF performed evaluations and custom fittings of wheelchairs for over 700 Kansans residing in over 80 counties. Their clients have long-term chronic conditions which can include cerebral palsy, neuromuscular disease, multiple sclerosis, spinal cord injuries, spina bifida, chronic obstructive pulmonary disease, congestive heart failure, etc. In CPRF's opinion, there are many reasons to be concerned with the current competitive bidding process established by CMS. Occupational and physical therapists rely on the expertise of the DME provider for individual equipment recommendations for each of their clients. CPRF uses four providers who have years of experience. The DME providers do more than provide wheelchairs. The providers must know the unique rules and regulations for each third party payer. These DME providers coordinate all documentation with the insurer and with the client's doctors, order and inventory the wheelchair frames and individual seating components, follow-up with each client, and provide warranty work as needed. The few DME providers used by CPRF are unique in that they have made a commitment to quality service, not only to the clinic, but also to the clients. It appears the competitive bidding program will lead DME provider bid winners to severely under bid the contracts for a given area, so that they can continue to survive. CPRF asserts this could force them to recommend inappropriate wheelchairs for their clients because that is all the DME bid winner can afford to provide. Medicare and Kansas Medicaid are the dominant payers of the wheelchairs CPRF recommends. If Kansas Medicaid adopts the current competitive bidding system without meaningful changes, CPRF believes it is likely that many of the high quality DME providers they use will have to close. In closing, Mr. Kemp stated the idea of pursuing cost reduction is admirable and needed. But, in CPRF's opinion, the current competitive bidding process has serious consequences for disabled Kansans and the current provider network that serves these individuals.

Upon completion of the testimonies on the CMS Competitive Bidding Program for Durable Equipment, Chairman Bethell turned the Committee's attention to the expansion of the scope of practice for dental hygienists.

Kevin Robertson, Executive Director and CAE, Kansas Dental Association presented his testimony related to the expansion of the scope of practice for dental hygienists. Mr. Robertson provided written copy of this testimony (Attachment 7). He stated, since the Kansas Dental Association (KDA) believes it is essential that all Kansans have access to good oral health care, the Association is very interested in working with the members of the dental team to enhance and increase the care provided to patients under various levels of dental supervision. In 2002, the KDA and the Kansas Dental Hygienist Association hammered out the agreement that became the Extended Care Permit (ECP) Dental Hygienist. The KDA was also involved and supported changes to the ECP I and II legislation in 2007. KDA believes strongly that prevention is the most cost effective and promising strategy to improve the oral health of Kansas citizens in all settings, and the dental hygienist is the dental team prevention specialist. The KDA is exploring a concept that combines the work of the Community Dental Health Coordinator (CDHC) dental team member concept piloted by the ADA, and expands upon the Extended Care Permit (ECP) dental hygienist role to create a dental community health worker of sorts. The concept would create a new level of ECP, an ECP III, whereby a dental hygienist would be required to complete some social work/counseling education regarding underserved populations, as well as training on providing additional dental

services. These dental services might include evaluation, temporary fillings and other emergency stabilization techniques. The ECP III would not perform surgical and diagnostic procedures, instead they would concentrate on preventative services, dental education, case management and emergency procedures to help change habits and get patients into a dental home with regular dental care. The KDA has established a task force charged with working out the details of this concept.

The KDA also believes that Kansas should increase the number of dental seats Kansas has with UMKC by five or six per year, add another dental school, or do both. KDA feels it is time to require the dentists in those seats, as part of their dental school admission, to return to Kansas to practice in an underserved area for a certain number of years. The Association will also ask the Legislature to again implement a dental student loan repayment bridging loan program that would provide an incentive for dental graduates to locate their practice in underserved areas of Kansas. In closing, Mr. Robertson stated Kansas dentists currently fund, administer and support two programs for adult dental care in Kansas through the Donated Dental Services program and the Kansas Mission of Mercy. It is estimated that the average dentist provides $33,000 in charity and reduced-fee care to patients every year. This amounts to $46.3 million in free and reduced care provided annually by Kansas dentists to Kansans. A question and answer session followed.

Maggie Smet, RDH, President of Kansas Dental Hygienists' Association, in private practice in Wichita, Kansas, provided her testimony on the expansion of the scope of practice for dental hygienists. Ms. Smet presented written copy of her testimony (Attachment 8). She is a registered dental hygienist and was the first Extended Care Permit (ECP) provider. Kansas has approximately 1739 Registered Dental Hygienists and 1430 practicing dentists. Ms. Smet explained the scope of practice of ECP hygienists, outlining the services they may provide, and the locations and persons the ECP hygienist may serve. None of the dentists who supervise ECP hygienists were educated in Kansas due to the absence of a dental school in the state. At this time approximately 127 Kansas dental hygienists hold an Extended Care Permit and primarily work in conjunction with one of 19 safety net dental clinics in Kansas. In closing, Ms. Smet stated the Kansas Dental Hygienists' Association urges the Kansas Legislature to support enhancements to the current ECP legislation to allow these preventive oral care providers easier access to those populations in need, and to consider implementation of a new mid-level oral health practitioner to help fill the enormous gaps in access to oral health care. A question and answer session followed with Chairman Bethell requesting an outline of the extended program envisioned by the Kansas Dental Hygienists' Association. Ms. Smet stated she would provide that information to the Committee.

Doreen Eyler, Extended Care Permit Hygienist, Grace Med in Wichita, Kansas, spoke regarding the expansion of the scope of practice for dental hygienists. Ms. Eyler presented written copy of her testimony (Attachment 9). Grace Med is one of the 19 safety net clinics in Kansas. Ms. Eyler described the nature of the services performed by Grace Med ECP I and II hygienists and the outreach sites served. She shared the access issues resulting from the lack of transportation and the cost of dental procedures, and stressed the importance of preventative dentistry. The sponsoring dentists required for ECP hygienists working at Grace Med are the dentists employed by Grace Med. Grace Med employs three full time dentists and two part time dentists, and the clinic schedules are consistently full. The Grace Med ECP hygienists are doing full time outreach and providing clinical hygiene to manage the high demand for preventative services. They navigate the Kansas population through their health and dental needs, along with spreading the word about prevention. A question and answer session followed.

Chairman Bethell introduced Tanya Dorf Brunner, Executive Director, Oral Health Kansas, to testify regarding expanding the scope of practice for dental hygienists. Ms. Brunner presented written copy of her testimony (Attachment 10). She stated, in 2003, the Legislature established Extended Care Permits (ECP) for Kansas dental hygienists to allow for the provision of hygiene services for low-income children and adults in community health centers and prisons. The law was

revised in 2007 to expand the scope of practice to include community-based services for persons with developmental disabilities and the elderly. The Kansas Department of Health and Environment (KDHE) Bureau of Oral Health published a Kansas dental workforce study in 2009. The study included a comprehensive look at ECP hygienists. Two-thirds of the ECP hygienists surveyed indicated they sought the ECP permit to help serve the underserved population. Eighty percent of the respondents said they are working at least a few hours a week as an ECP hygienist, and 38 percent reported they are not using their ECP permit to the extent they would prefer. The workforce study also questioned respondents as to the barriers encountered in beginning their ECP practice. The ECP hygienists stated the barriers included the lack of current feasibility in making a living doing only ECP work because running an effective ECP program involves a lot of non-billable time for outreach and paperwork, and also the lack of Medicaid coverage for adult preventative services. Another obstacle, is that some schools also are hesitant to provide ECP hygienists access to the free and reduced price school lunch list. Lastly, if ECP hygienists are able to operate on their own, they still need to find a dentist or dentists who are willing to do the restorative work the ECP hygienist finds is needed.

Oral Health Kansas is partnering with the KDHE Bureau of Oral Health to facilitate an ECP Policy Work Group for the purpose of examining the potential barriers in the law to ECP hygienists' ability to practice. The work group plans to formulate policy recommendations by the end of the year.

Dr. Andy Tompkins, President and CEO, Kansas Board of Regents, provided testimony related to the expansion of the scope of practice for dental hygienists. Dr. Tompkins presented a written copy of his testimony (Attachment 11). He stated the issue of dental service in Kansas is certainly not a new one. Kansas has taken several actions to compensate for the fact that it lacks a dental school, perhaps the most significant being the development of a reciprocity agreement that allows Kansans to study dentistry at the University of Missouri-Kansas City (UMKC) Dental School at in-state tuition rates. Dr. Tompkins stated Kansas currently has five programs training dental assistants and five educating dental hygienists. Kansas also has one graduate certificate program located at Wichita State University (WSU). In closing, Dr. Tompkins stated he had been in contact with Kansas University (KU) and WSU administrators regarding the establishment of a dental school in Kansas, and noted it would be a very costly endeavor. He discussed several options other than the pursuit of a dental school. These options were:

- Enact a service requirement for Kansas residents attending UMKC dental programs and receiving our-of-state tuition waivers; and

- Establish a scholarship program for dental students that pays the difference between in-state and out-of-state tuition at dental schools other than UMKC. These scholarships would come with a service requirement that might include additional incentives to work in underserved geographic areas of Kansas.

A short question and answer session followed.

Chairman Bethell called the Committee's attention to the "written only" testimonies of Debra Harmon Zehr, President and CEO of the Kansas Association of Homes and Services for the Aging (Attachment 12), and Connie Hubbell, Governmental Affairs Director for the Kansas Association for the Medically Underserved (Attachment 13).

Chairman Bethell recessed the meeting at 12:40 p.m and announced the afternoon session would begin at 1:45 p.m.

Afternoon Session

Chairman Bethel reconvened the meeting at 2:00 p.m. and introduced Ray Dalton, Deputy Secretary, Kansas Department of Social and Rehabilitation Services, to provide follow-up data on adult abuse and neglect in the Frail Elderly (FE) Waiver. Deputy Secretary Dalton presented written copy of his testimony (Attachment 14). He provided information on Adult Protective Service Substantiations and Rates Comparison of Pre and Post-Policy by Age, Parent Fee Program, Parent Fee Schedule, and Parent Fee Program Collection information which was requested by the Committee at an earlier committee meeting. A short question and answer session followed.

Martin Kennedy, Secretary, Kansas Department on Aging, provided an update on the Provider Assessment Advisory Panel. Secretary Kennedy presented written copy of his update (Attachment 15). He provided a list of panel members to date and stated the four Governor's appointees to the panel were pending. A question and answer session followed.

Chairman Bethell called on Bill McDaniel, Program and Policy Commissioner, Kansas Department on Aging, to give a follow-up on the use of the Program for All-inclusive Care for the Elderly (PACE) funds to address other budget needs. Mr. McDaniel presented written copy of his testimony (Attachment 16). He reviewed the charts and graphs provided to the Committee. Mr. McDaniel stated there are two PACE programs in Kansas: Via Christi Hope and Midland Connections. The total number of slots approved for Hope is 305 and for Midland, 100. Both are growing and will probably cap out at the end of this year. Mr. McDaniel also stated a 3% rate increase was placed in the enhancement.

A lengthy question and answer session followed resulting in these requests for information:

- Actual expenditures for Via Christi and Midland Connections on the PACE program;
- A cost benefit analysis for cost savings to the programs; and
- A comparison of the PACE rate and the non-PACE fee for service.

Mr. McDaniel agreed to provide the requested information.

Deputy Secretary Dalton, Kansas Department of Social and Rehabilitation Services, was called on to provide a follow-up on the Autism Waiver Parent Fee Program (Sliding Fee Scale). Deputy Secretary Dalton referred the Committee to the charts in his earlier handout (Attachment 14, Pages 2, 3, and 4) He provided information on the number of families in the program by fee level and waiver, the parent fee schedule, and collections through the Parent Fee Program. A discussion followed regarding the information presented on the charts.

There being no other questions, Deputy Secretary Dalton moved the Committee's attention to the FY 2010 Annual Report on the average number of individuals transferred from state and private institutions to HCBS including the Average Daily Census for State Institutions and Long Term Care Facilities, Savings on Transfers to HCBS Waiver, and HCBS Savings Fund Balance; and a FY 2011 First Quarter Report on the number of individuals transferred to HCBS Services. Deputy Secretary Dalton provided a follow-up SRS Report on Mental Health Facility Numbers from 2005-2010. He referred the Committee to his earlier handout (Attachment 14, Page 5, 6, 7, and 8) and reviewed the charts for the Committee.

A question and answer session followed during which questions were posed regarding the zero balance in both the SRS HCBS Services Savings Fund and the KDOA HCBS Savings Fund. Deputy Secretary Dalton explained that, in order to realize savings, units would need to close, not just beds. However, if the budget is cut resulting in a unit being closed, no savings is realized because the funds are already gone due to the budget cut.

Chairman Bethell indicated the minutes of the meeting held on September 8, 2010 were previously distributed and *upon a motion by Representative Mast and a second by Senator Kultala to approve the minutes as written, the motion passed.*

Chairman Bethell introduced Scott Brunner, Chief Financial Officer, Kansas Health Policy Authority, to provide a follow-up on the Kansas Health Policy Authority's application processing procedure, the Clearinghouse backlog, and application processing changes being implemented. Mr. Brunner presented written copy of his testimony (Attachment 17). He provided a flow chart of the application processing system. The Clearinghouse is a centralized processing center which manages family medical eligibility determinations. It is operated by a private vendor through a competitive contract. The Clearinghouse processes applications and renewals through a mail-in process. Mr. Brunner stated that, in 2009 and continuing into 2010, a number of factors converged to create a large backlog of applications. KHPA has taken several steps to find a solution to the backlog of applications and the resulting delays in eligibility experienced by thousands of applicants. Mr. Brunner indicated that, as of November 1, 2010, the backlog numbers totaled 17,789 applications over 45 days old. He further stated that KHPA is now on track to resolve this backlog by March 2011.

A lengthy discussion followed with members of the Committee voicing their concerns regarding the delays in the application process. During the discussion, Scott Brunner explained how the applications were processed. Darin Bodenhamer, Medicaid Director of Eligibility at KHPA, entered the discussion explaining the oldest applications were processed first. Chairman Bethell requested KHPA provide a more detailed flow sheet of the application process before December 8, 2010. Chairman Bethell also requested information regarding the amount of money the state of Kansas has saved as a result of the Clearinghouse backlog with differentiation between State General Funds and federal funds.

Mr. Brunner invited the Committee to tour the Clearinghouse facility to observe the application processing system. Chairperson Bethell accepted the invitation and indicated he would consult with the Committee for a date when a majority of the members would be available for a tour.

Chairman Bethell turned the Committee's attention to proposed recommendations. Based on testimony heard and Committee deliberations, the Joint Committee on Home and Community Based Services Oversight made the following recommendations:

- **Access to Dental Care.** The Kansas Dental Association, the Kansas Dental Hygienists' Association, Kansas Association for the Medically Underserved (KAMU), Oral Health Kansas, safety net clinics, and any other groups relevant to the dental health care issue are encouraged to meet to discuss possible means to address the lack of access to dental health care. These groups are encouraged to present either joint or separate legislation during the 2011 Legislative Session to address the concerns.

- **Autism Waiver.** The appropriate legislative committees and members of the Executive branch are requested to consider legislating additional slots in the Autism Waiver during the 2011 Legislative Session.

- **Telehealth Program.** The Department on Aging is directed to again bring the Telehealth Program to the attention of the Legislature because this issue remains valid.

- **Extended Care Permit Expansion.** The ECP Policy Workgroup being facilitated by Oral Health Kansas and KDHE Bureau of Oral Health is encouraged to formulate policy recommendations articulating an Extended Care Permit expansion to meet the dental health care needs in the state to be considered during the 2011 Legislative Session.

- **Provider Assessment for HCBS DD Waiver.** The appropriate legislative committees and members of the Executive branch are requested to consider the expansion of the provider assessment program to include the HCBS Developmental Disability Waiver.

- **Community-Based Mental Health Services.** The 2011 Legislature is requested to look at the funding for the state's mental health system with the view of preventing further reductions in those services and address the issue of insufficient beds for mental health care. For FY 2012, as revenues allow, it is recommended that the 2011 Legislature begin restoring the cuts sustained by the mental health system.

- **Expansion of PACE Program.** The 2011 Legislature is requested to continue considering the expansion of the Program for All-inclusive Care for the Elderly (PACE) for FY 2012, as funding allows.

- **KHPA Clearinghouse Backlog.** The Kansas Health Policy Authority is encouraged to resolve the backlog in processing applications and renewals for determining medical benefit eligibility in a timely manner.

Chairman Bethell thanked all conferees and Committee members for their input and attention. The meeting was adjourned at 4:00 p.m. with no other meetings scheduled.

Subsequent to the committee meeting, the need to clarify information provided by Kevin Robertson (Kansas Dental Association) in his testimony came to the attention of the Committee. Mr. Robertson provided a letter dated November 23, 2010, explaining the information in question (Attachment 18). The letter was forwarded to Committee members for their review, and is herein incorporated as part of the testimony.

Prepared by Jackie Lunn
Edited by Iraida Orr

Approved by Committee on:

December 30, 2010
(Date)

2010 JOINT COMMITTEE ON HOME AND COMMUNITY BASED SERVICES OVERSIGHT

Senate	House
Sen. Carolyn McGinn, Vice-chairperson	Rep. Bob Bethell, Chairperson
Sen. Laura Kelly	Rep. Jerry Henry
Sen. Kelly Kultala	Rep. Brenda Landwehr
Sen. Dwayne Umbarger	Rep. Peggy Mast
	Rep. Melody McCray-Miller

Kansas Legislative Research Department

Iraida Orr, Kathie Sparks, Amy Deckard
Jackie Lunn, Committee Secretary

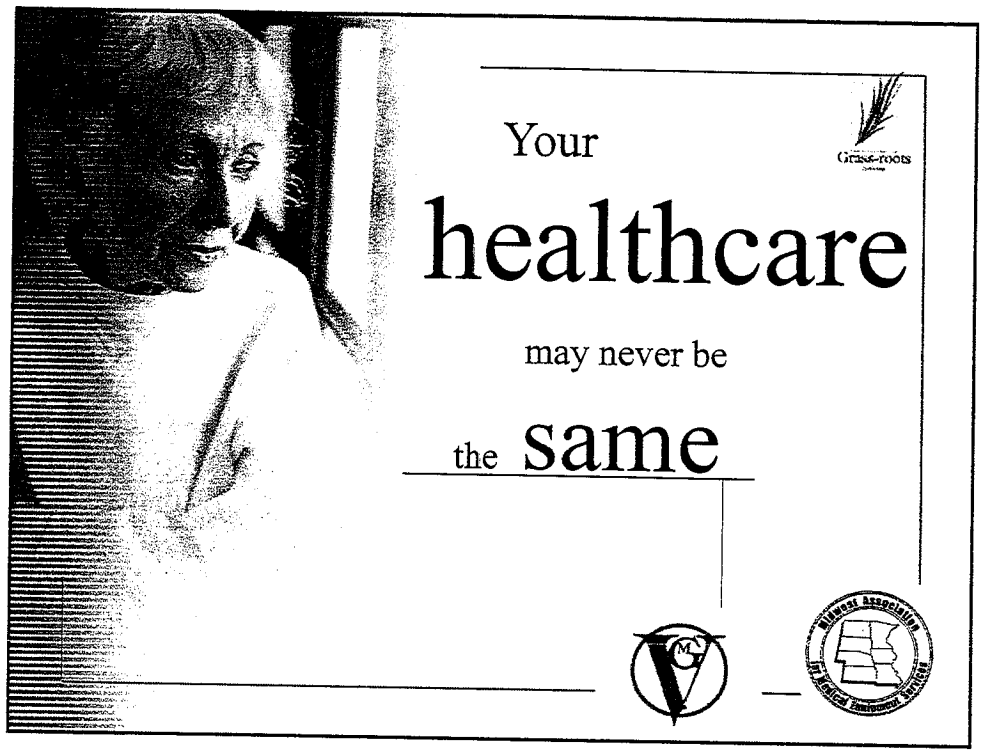
Revisor of Statutes Office

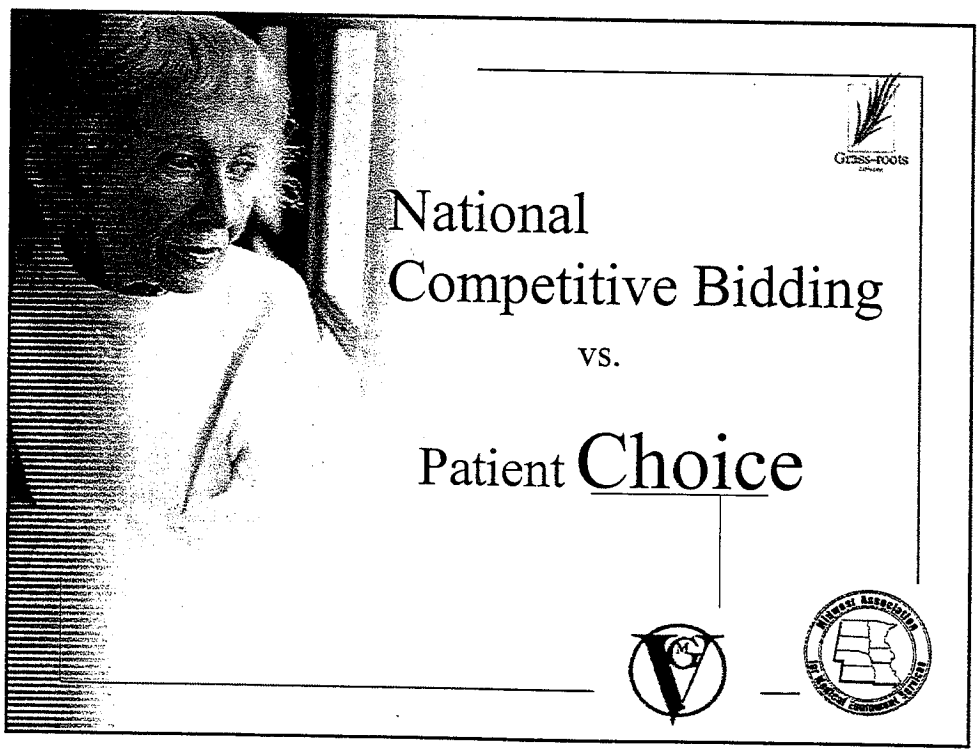
Doug Taylor, Nobuko Folmsbee

CHARGE

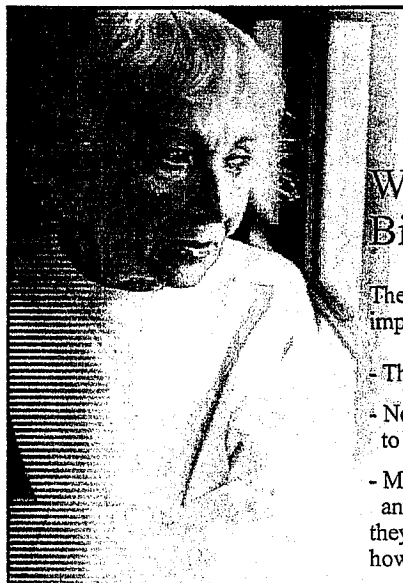
To help ensure that long-term care services, including home and community based services, are provided through a comprehensive and coordinated system throughout the state, the Committee is to oversee the savings resulting from the transfer of individuals from state or private institutions to home and community based services and to ensure that any proceeds resulting from the successful transfer be applied to the system for the provision of services for long-term care and home and community based services. Additionally, the Committee is to review and study other components of the state's long-term care system.

Home and Community Based Services Oversight
Date: 11-8-10
Attachment: #1





Home and Community Based
Services Oversight
Date: 11-8-10
Attachment: #2



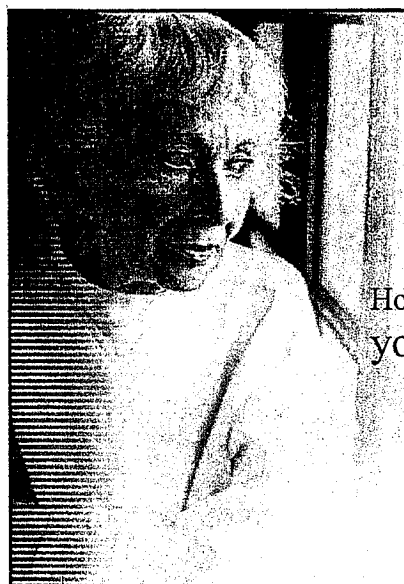
Grass-roots

What is Competitive Bidding?

The basic premise is that the government will implement cost controls in an effort to save money

- The lowest bid will get the government contract
- Not used for any Medicare service on product up to today
- Medicare beneficiaries are now free to buy from any qualified provider, and may switch providers if they are not receiving quality care. Under this program, however, this will NOT be the case.

National Competitive Bidding vs. Patient Choice



Grass-roots

How Competitive bidding affects you, the Medicare beneficiary!

1) Choice
2) Quality of service and care
3) Innovation
4) Monopoly/Expanded Government

National Competitive Bidding vs. Patient Choice

Grass-roots

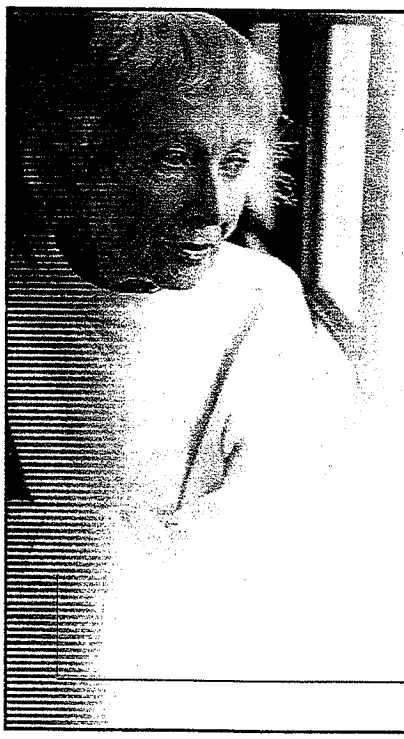
Why

the basic premise

of Competitive Bidding

is invalid

National Competitive Bidding vs. Patient Choice



Grass-roots

Rotech's Financial Trouble

Rotech's stock closed at $0.87; the closing price was $1 on July 14. First-quarter financial results show the company $514.6 million in debt with $58.7 million in cash. The Accredited Medical Equipment Providers of America noted that, in a May 10 filing with the Securities and Exchange Commission, Rotech said the company "may be required to consider all of our alternatives in restructuring our business and our capital structure, including filing for bankruptcy protection."

Rotech Healthcare Inc. (OTCBB: ROHI) today announced that it has accepted 17 contracts awarded by the Centers for Medicare & Medicaid Services ("CMS") in the Round 1 Rebid of the national Medicare Competitive Bidding Program. The Round 1 Rebid included nine metropolitan statistical areas ("MSAs"). Rotech has accepted the following contracts:

6 MSAs for oxygen supplies and equipment;
6 MSAs for enteral nutrients, equipment and supplies;
3 MSAs for CPAP, RADs and related supplies and accessories; and
2 MSAs for standard power wheelchairs, scooters and related accessories.

BusinessWire · Monday, Jul. 12, 2010

"We are pleased with our success in the Round 1 Rebid of the national competitive bidding program and we look forward to further growth and expansion of our existing presence in these initial cities," commented Philip L. Carter, Rotech's President and Chief Executive Officer.

"The new payment rates for our six oxygen contracts averaged approximately 30% off the current applicable Medicare payment rates," Mr. Carter continued. "Not assuming any market share gains, the application of the new competitive bid rates to our existing patient base in these nine MSAs reduces our revenue by approximately $900,000 in the first quarter of 2011,

he explained, adding that, "We believe, however, that our market share gains in the cities where we were awarded contracts will more than offset the reductions in reimbursement rates over time."

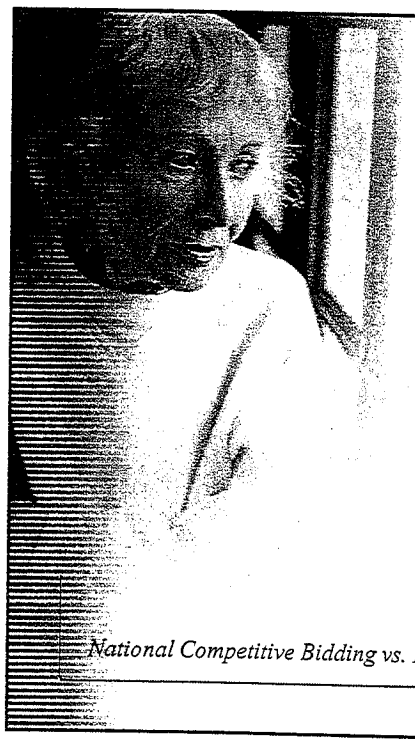
2-4

Rotech Bid Winners in the Kansas City CBA:

Berkeley Medical Equipment – Emporia, KS

Collins Rentals – Trenton, MO

Value Care – Marshall, MO



Choice

- Patients will have dramatically reduced choice of homecare providers
- **Rural and underserved areas** will be hardest hit
- Patients will be forced to travel to larger cities to receive health care products/services

The small, independent, community-based homecare dealer will no longer exist. What impact will this have?

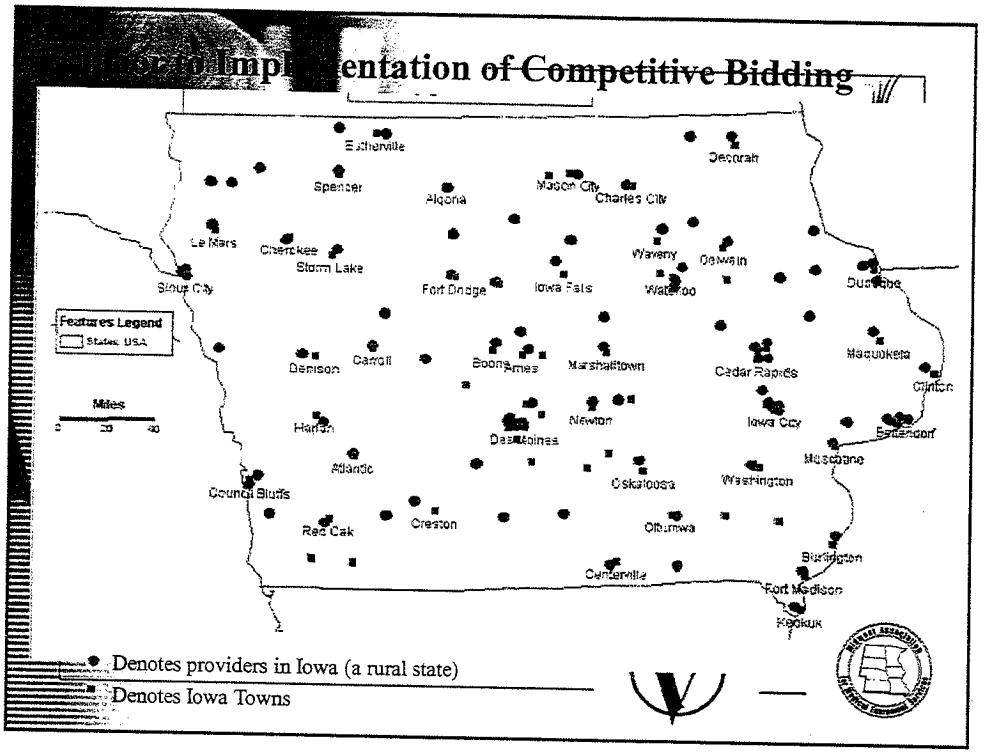
Question: *Do we really want the government to dictate from whom you get your healthcare products and services?*

National Competitive Bidding vs. Patient Choice

Rural/Underserved Areas will be Hardest Hit

Members of Congress may argue that rural areas will not be affected because "competitive" bidding will not be implemented in those areas. But when **third-party payers and Medicaid reimbursements begin to reflect the low-ball prices from this program,** patients in rural areas will be the hardest hit. The low prices will make it difficult for local, independent home medical equipment providers to keep their doors open; and rural patients will **no longer have access to the quality care and services that they need.**

A **reduction** in home medical equipment providers will have a significant **negative impact** on patient access to **quality care**!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Sioux City
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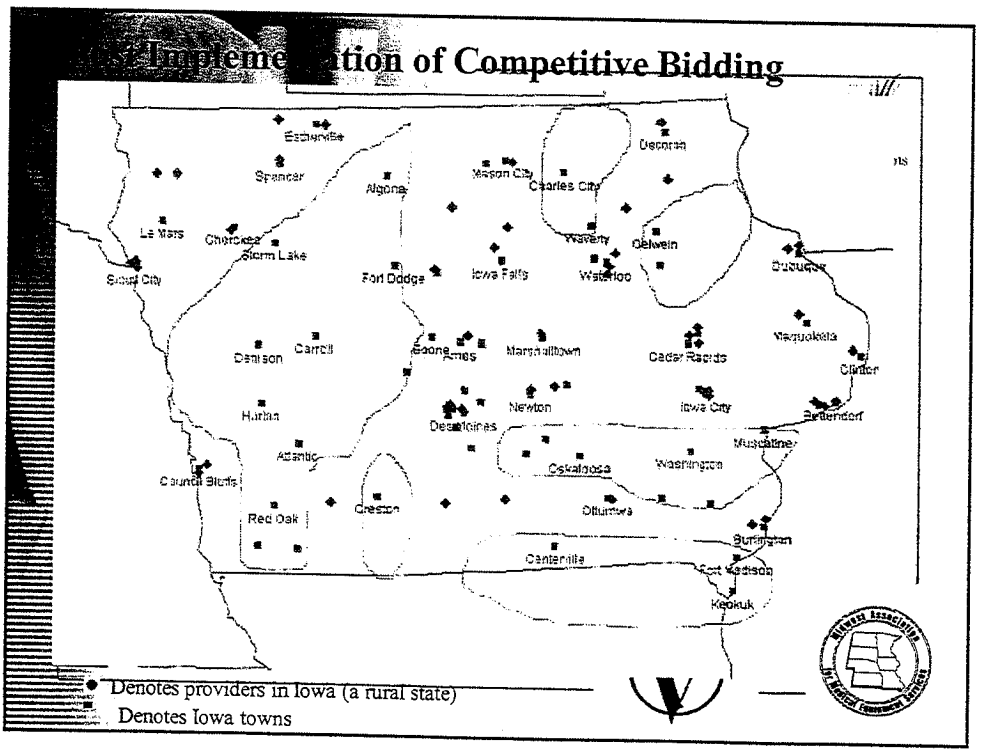
Iowa Falls
Waterloo
Dubuque
Features Legend
States, USA
Miles
Denison
Carroll
Boone
Ames
Marshalltown
Cedar Rapids
Maquoketa
Clinton
Harlan
Newton
Iowa City
Bettendorf
Atlantic
Des Moines
Muscatine
Council Bluffs
Oskaloosa
Washington
Red Oak
Creston
Ottumwa
Centerville
Burlington
Fort Madison
Keokuk
Denotes providers in Iowa (a rural state)
Denotes Iowa Towns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Bettendorf
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Oskaloosa
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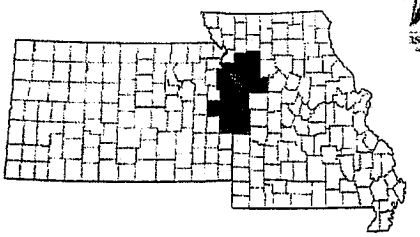
Burlington
Centerville
Fort Madison
Keokuk
Denotes providers in Iowa (a rural state)
Denotes Iowa towns



The **Kansas City Metropolitan Area** is a metropolitan area situated at the confluence of the Kansas and Missouri Rivers (Kaw Point) and straddling the state border between Missouri and Kansas. The 15-county Kansas City Metropolitan Statistical Area, anchored by Kansas City, Missouri, is the 27th largest in the United States with an estimated population of 1,947,694 in the year 2005. The Combined Statistical Area also includes the Micropolitan Statistical Areas of Atchison, Kansas, and Warrensburg, Missouri, with estimated populations of 10,232 and 16,741, respectively. The Combined Statistical Area of Kansas City had a population of 2,015,282 in the year 2005.

Reduced Service

The few home healthcare providers left will face severe budget constraints, and the first thing that will be cut is service, including preventive equipment maintenance, patient education, 24-hour on-call service and care by professional respiratory therapists.

Question: *Have you ever seen large healthcare chains increase service and quality when competition is eliminated?*

National Competitive Bidding vs. Patient Choice

Grass-roots

Curtailed innovation

As reimbursements are forced down, manufacturers will have no economic incentive to continue to develop innovative products and enhancements.

Manufacturers will be incented to produce cheap equipment offshore with no regard for the quality of life that patients expect and deserve.

Question: *Once competition is eliminated through competitive bidding, do you believe large national chain stores will spend extra on innovation, quality products?*

Grass-roots

Monopoly/Expanded Government

Small business, especially in small communities, is the engine of the U.S. economy. Seventy percent of all new employment is through small business.

By all estimates, competitive bidding will eliminate 40 to 60 percent of independent home medical equipment dealers nationally. All that will be left will be the "Big Box" national chains located in larger cities. Competitive bidding will require an expanded government bureaucracy to administer.

Question: *Do we really want our government to create a monopoly in our healthcare industry? Do we really want to see a bigger government to run Competitive Bidding?*

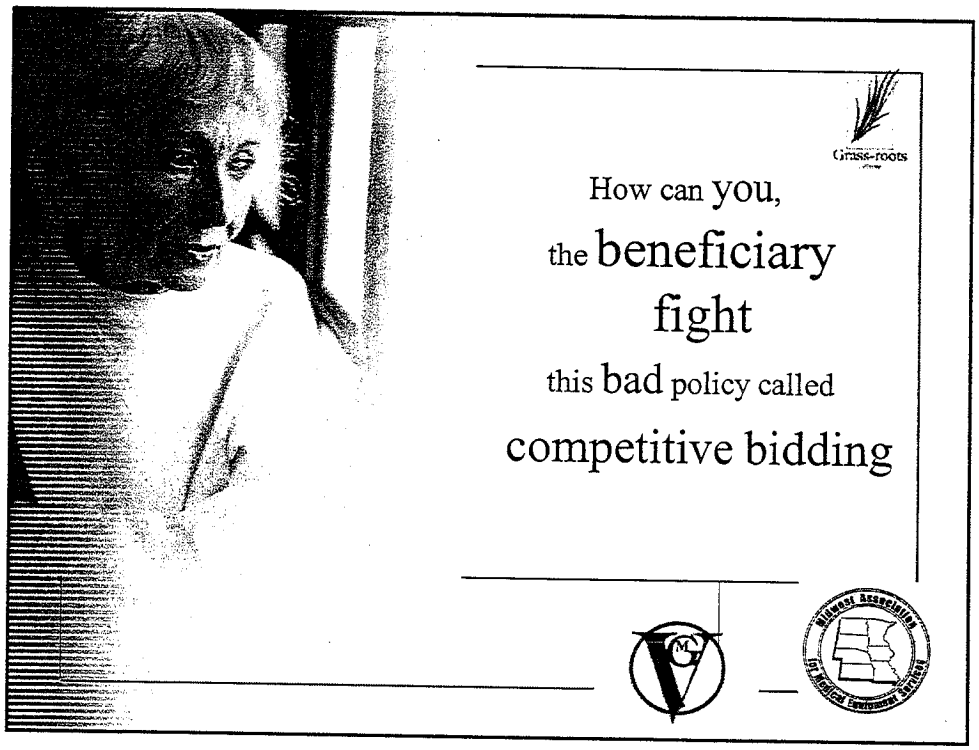
What Do The Experts Say?

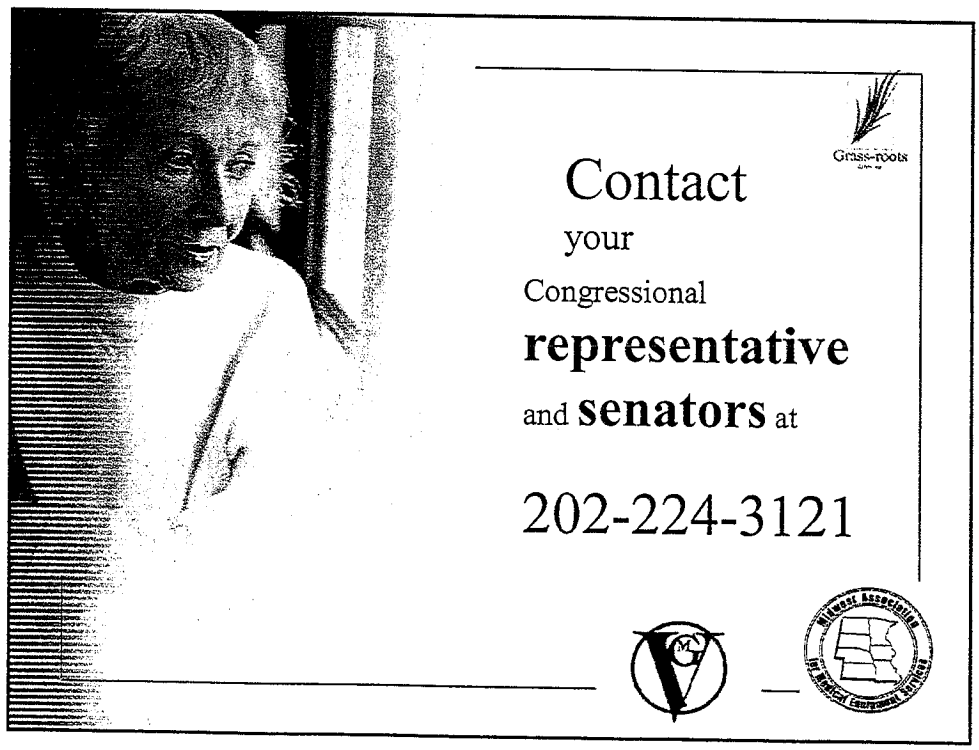
- Letter from 167 Concerned Auction Experts

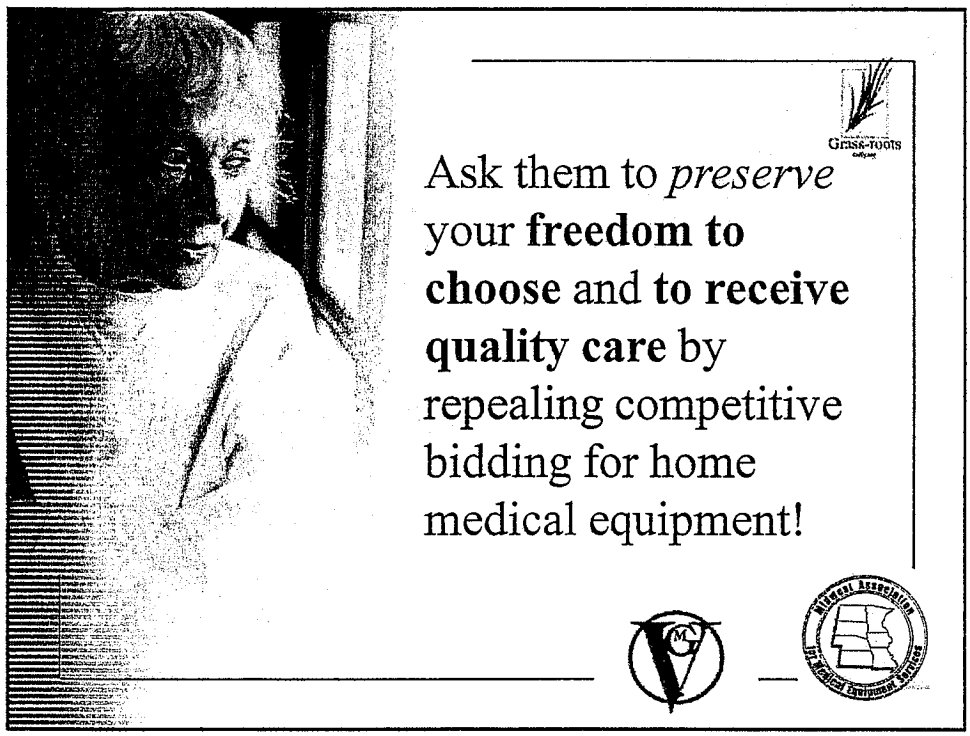
National Competitive Bidding is **BAD** government policy and is **BAD** for patients who rely on medically **necessary** equipment

National Competitive Bidding vs. Patient Choice

2-10


Grass-roots
How can you,
the beneficiary
fight
this bad policy called
competitive bidding


Grass-roots
Contact
your
Congressional
representative
and senators at
202-224-3121


Ask them to *preserve* your **freedom to choose** and **to receive quality care** by repealing competitive bidding for home medical equipment!

2-12

26 September 2010

The Honorable Pete Stark
Chairman
Subcommittee on Health
Committee on Ways and Means
239 Cannon Building
Washington, DC 20515

Dear Chairman Stark:

We are economists, computer scientists, and operation researchers with expertise in the theory and practice of auctions.[1] We write to express our concerns with the Medicare Competitive Bidding Program for Durable Medical Equipment operated by the U.S. Department of Health and Human Services. We believe that competitive bidding can be an effective method of controlling Medicare costs without sacrificing quality. However, the current auction program has flaws that need to be fixed before it can achieve the objectives of low cost and high quality.

Four main problems

The first problem is that the auction rules violate a basic principle of auction design: *bids must be binding commitments*. In the Medicare auction, bidders are not bound by their bids. Any auction winner can decline to sign a supply contract following the auction. This undermines the credibility of bids, and encourages low-ball bids in which the supplier acquires at no cost the option to sign a supply contract.

The second problem is a flawed pricing rule. As is standard in multi-unit procurement auctions, bids are sorted from lowest to highest, and winners are selected, lowest bid first, until the cumulative supply quantity equals the estimated demand. What is odd is that rather than paying winners the clearing price (the last-accepted bid), the auction pays winners the unweighted median among the winning bids. This is unique in our collective experience. The result is that fifty percent of the winning bidders are offered a contract price *less than* their bids. This median pricing rule further encourages low-ball bids, since a low bid guarantees winning, has a negligible effect on the price and gives the supplier a free option to sign a supply contract. Even if suppliers bid their true costs, up to one-half of the winning suppliers would reject the supply contract and the government would be left with insufficient supply. Others may accept the contract and cross-subsidize public patients with the revenue from private patients, or just take a loss. This pricing rule does not develop a sustainable competitive bidding process or healthy supplier pool.

The third problem arises from the use of composite bids, an average of a bidder's bids across many products weighted by government estimated demand. This provides strong incentives to distort bids away from costs—the problem of bid skewing. Bidders bid low on products where the government overestimated demand and high on products where the government underestimated demand. As a result, prices for individual products are not closely related to costs. Bid skewing is especially

[1] The views expressed here are our own and do not represent the views of any organization. For additional information please contact Peter Cramton, University of Maryland, pcramton@gmail.com.

problematic in this setting, since the divergence between costs and prices likely will result in selective fulfillment of customer orders. Orders for low-priced products are apt to go unfilled.

The fourth problem is a lack of transparency. It is unclear how quantities associated with each bidder are determined. These quantities are set in a non-transparent way in advance of the auction. Bids from the last auction event were taken in November 2009, and now more than ten months later, we still do not know who won contracts. Both quality standards and performance obligations are unclear. This lack of transparency is unacceptable in a government auction and is in sharp contrast to well-run government auctions such as the Federal Communications Commission spectrum auctions.

This collection of problems suggests that the program over time may degenerate into a "race to the bottom" in which suppliers become increasingly unreliable, product and service quality deteriorates, and supply shortages become common. Contract enforcement would become increasingly difficult and fraud and abuse would grow.

Key features of a good auction design

Competitive bidding techniques have improved dramatically over the past twenty years and especially in recent years. Complex auctions like the Medicare competitive bidding program can be designed to achieve the objectives of low cost and high quality with little implementation risk. Successful government auctions emphasize transparency, good price and assignment discovery, and strategic simplicity. The result is sustainable long-term competition among suppliers which reduces costs while maintaining quality.

We recommend that the government fix the flaws in the current auction program and develop a new design that emphasizes the key features of successful designs. Implementation of the current design will result in a failed government program. There is no need for a bad outcome. With state-of-the-art auction methods and careful implementation, the auction program can succeed in reducing costs while maintaining quality—a win-win for both taxpayers and Medicare beneficiaries.

Respectfully submitted,

[The following are economists, computer scientists, and operation researchers with expertise in the design of auctions and market mechanisms. Information on each of us, including our auction-related research, can be found with an Internet search of name and affiliation.]

Dilip Abreu
Princeton University

Itai Ashlagi
MIT

Susan Athey
Harvard University

Lawrence M. Ausubel
University of Maryland

Chris Avery
Harvard University

Ian Ayres
Yale University

Kerry Back
Rice University

Patrick L. Bajari
University of Minnesota

Sandeep Baliga
Northwestern University

Michael Ball
University of Maryland

David Baron
Stanford University

Michael Baye
Indiana University

Coleman Bazelon
Brattle Group

Dirk Bergemann
Yale University

Gary A. Biglaiser
University of North Carolina

Sushil Bikhchandani
UCLA

Kenneth Binmore
University College London

Andreas Blume
University of Pittsburgh

Simon Board
UCLA

Gary Bolton
Pennsylvania State University

Tilman Borgers
University of Michigan

Eric Budish
University of Chicago

James Bushnell
Iowa State University

Estelle Cantillon
Université Libre de Bruxelles

Andrew Caplin
New York University

Marco Celentani
Universidad Carlos III

Kalyan Chatterjee
Pennsylvania State University

Yeon-Koo Che
Columbia University

In-Koo Cho
University of Illinois

Peter Coles
Harvard University

Peter Cramton
University of Maryland

Vincent Crawford
University of Oxford

Jacques Cremer
Toulouse School of Economics

Robert Day
University of Connecticut

Luciano I. de Castro
Northwestern University

Francesco Decarolis
University of Wisconsin

George Deltas
University of Illinois

Peter DeMarzo
Stanford University

Raymond J. Deneckere
University of Wisconsin-Madison

Nicola Dimitri
University of Siena

David Dranove
Northwestern University

Marc Dudey
Rice University

Gregory M. Duncan
Brattle Group

Jeffrey Ely
Northwestern University

Itay Fainmesser
Brown University

Emel Filiz-Ozbay
University of Maryland

Dan Friedman
University of California Santa Cruz

Douglas Gale
New York University

Lawrence R. Glosten
Columbia University

Theodore Groves
University of California San Diego

Philip A. Haile
Yale University

Milton Harris
University of Chicago

Ronald M. Harstad
University of Missouri

Oliver Hart
Harvard University

Jason Hartline
Northwestern University

John Hatfield
Stanford University

Donald Hausch
University of Wisconsin

Robert Hauswald
American University

Thomas W. Hazlett
George Mason University

Kenneth Hendricks
University of Wisconsin

Karla Hoffman
George Mason University

William W. Hogan
Harvard University

Charles A. Holt
University of Virginia

Ali Hortacsu
University of Chicago

Daniel Houser
George Mason University

Nicole Immorlica
Northwestern University

R. Mark Isaac
Florida State University

Philippe Jehiel
Paris School of Economics

Thomas D. Jeitschko
Michigan State University

John Kagel
Ohio State University

Charles Kahn
University of Illinois

Ehud Kalai
Northwestern University

Michael L. Katz
University of California Berkeley

Brett E. Katzman
Kennesaw State University

Paul R. Kleindorfer
University of Pennsylvania

Kala Krishna
Pennsylvania State University

Michael Landsberger
University of Haifa

John Ledyard
California Institute of Technology

Jonathan D. Levin
Stanford University

David K. Levine
Washington University in St. Louis

Gregory Lewis
Harvard University

Tracy R. Lewis
Duke University

Kevin Leyton-Brown
University of British Columbia

Yuanchuan Lien
Hong Kong Univ. of Science & Tech.

Barton L. Lipman
Boston University

John List
University of Chicago

Jeffrey K. MacKie-Mason
University of Michigan

W. Bentley MacLeod
Columbia University

George J. Mailath
University of Pennsylvania

Timothy Mathews
Kennesaw State University

Steven A. Matthews
University of Pennsylvania

David McAdams
Duke University

Mark J. McCabe
University of Michigan

Flavio Menezes
University of Queensland

Paul Milgrom
Stanford University

Eugenio J. Miravete
University of Texas

John Morgan
University of California Berkeley

Stephen Morris
Princeton University

Herve Moulin
Rice University

Roger Myerson
University of Chicago

Dana S. Nau
University of Maryland

Axel Ockenfels
University of Cologne

Shmuel Oren
University of California Berkeley

Michael Ostrovsky
Stanford University

Erkut Ozbay
University of Maryland

Marco Pagnozzi
University of Naples

Mallesh Pai
University of Pennsylvania

Ariel Pakes
Harvard University

Thomas Palfrey
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David Parkes
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David Pearce
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John Riley
UCLA

Michael Riordan
Columbia University

Jacques Robert
HEC Montreal

Donald John Roberts
Stanford University

Gregory Rosston
Stanford University

Al Roth
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John Rust
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Maher Said
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Larry Samuelson
Yale University

William Samuelson
Boston University

Tuomas W. Sandholm
Carnegie Mellon University

Mark A. Satterthwaite
Northwestern University

Thomas C. Schelling
University of Maryland

William Schulze
Cornell University

Alan Schwartz
Yale University

Jesse Schwartz
Kennesaw State University

Michael Schwarz
Yahoo! Labs

Ilya Segal
Stanford University

Yoav Shoham
Stanford University

Martin Shubik
Yale University

Matthew Shum
California Institute of Technology

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Global Energy Policy Center

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Northwestern University

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Cornell University

Utku Unver
Boston College

Eric Van Damme
Tilburg University

Timonthy van Zandt
INSEAD

S. Viswanathan
Duke University

Rakesh Vohra
Northwestern University

Michael Waldman
Cornell University

Mark Walker
University of Arizona

Ruqu Wang
Queen's University

Steven R. Williams
University of Illinois

Bart Wilson
Chapman University

Robert Wilson
Stanford University

Catherine Wolfram
University of California Berkeley

Dennis Yao
Harvard University

Pai-Ling Yin
MIT

Jaime Zender
University of Colorado

Home Medical Equipment

Competitive Bidding

November 8th, 2010

Thank you for the opportunity to visit with you today regarding a program that is being touted as huge savings for Medicare, which in actuality be detrimental to our industry of Home Medical Equipment companies, but also a crippling program for our seniors and people with disabilities.

Our industry is constantly being required to do more and more, not only for beneficiaries but also regulatory constraints, and yet the reimbursement in our industry has not gone up in years, we have seen reimbursement cuts repeatedly, and now in addition the competitive bidding program translates into unsustainable reimbursement rates for providers. There are four main points that I would like you to consider.

- **Reduced access to care and service disruption –** This bidding program will restrict consumer access to care and choice for home medical items and services, and it will trigger a race to the bottom in terms of quality. Less expensive items will be provided to patients. After all, we are required to provide FREE Delivery, and supplies for equipment such as oxygen tanks, the tubings, cannulas, etc are also not billable but considered content of service. We are required to provide 24 Hr emergency service, which once again we are not allowed to bill for, nor for the follow ups and home assessments. So the only area in which you can cut expense is on the product itself. The program will disrupt the continuum and coordination of care between doctors, discharge planners, patients, and home medical equipment providers. With a loss of providers, expedient deliveries of items and services will be eliminated.

- **Higher Spending in Medicare –** The bidding program will increase Medicare costs. It will lead to longer, more expensive hospital stays and more physician office visits, nursing home admissions, and emergency room visits. **Home medical equipment and services represent the most cost-effective, slowest-growing portion of Medicare spending**, increasing only 0.75 percent per year. That compares to more than 6 percent annual growth for Medicare spending overall.
- Home medical equipment represents **only 1.6 percent of the entire Medicare budget.**

- **Less competition, not more-** The bid program is anti-competitive because it reduces the number of competitors. About 90 percent of qualified home medical service providers were barred from the Medicare program in the first round of bidding conducted in 2008.

Home and Community Based Services Oversight
Date: 11-8-10
Attachment: #3

- **Kansas City, Mo-KS**
- • Of the 248 suppliers in this market, only 104 contracts were awarded. This resulted in at least 58% of local suppliers being eliminated.
- • Providers with 25 years of local experience and extensive local market share and the capacity to serve the entire CBA were excluded from the winning pool.
- • There are approximately 223,500 Medicare beneficiaries in greater Kansas City who could be impacted.
- • A 58% reduction in suppliers translates to a 138% increase in the number of beneficiaries per supplier.
- • An estimated 15,000 local residents are Medicare patients on home oxygen therapy.
- • In Kansas City, 27% of referrals placed for walkers, enteral, oxygen or CPAP resulted in the contract winners turning down the referrals because they could not service the area or did not have the equipment.
- o Five (5) of the 11 contract winners contacted had no local office in the Kansas City CBA and this was the reason for two of the turndowns. The remainder stated they would have to drop-ship the products and that it would take several days to up to two weeks -- thus delaying hospital discharges and causing access to care issues.
- o Local providers were excluded, while CMS awarded contracts to providers who have locations only in Florida, Indiana, California, Tennessee and Texas.
- o An out-of-state contract supplier from California told Kansas City and Pittsburgh referral sources that they were not sure they could supply a walker to patients there, but if so, it would be shipped by UPS and take 10-12 days to deliver.
- o One enteral nutrition contract winner said they only supply nursing homes – no homecare.
- o One winner for the walkers product category said they only service one small town in Kansas and cannot accept referrals across the KC metro area (as required by the program).

As you see by the statistics the competitive bidding impacted the Kansas City area. Now compound those difficulties for areas such as ours which is considered rural. If we were unable to bid successfully in the program, it would mean our patients/customers who currently do business with us, would no longer have that option and would not understand having to go at least an hour away to obtain supplies or equipment. So what Congress in effect hase done is to take the beneficiaries right of choice away and is now dictating with who and where they will do business. These are not nameless people they are your family, neighbors and friends they are your constituents who look to you to see after their best interest.

- **Loss of jobs and small businesses**- The bidding program will result in the closing of thousands of small businesses and result in as many as 100,000 job losses nationwide (according to numbers by AA Homecare) In our town if forced to close, there would be 40 jobs lost, and a total of almost 600 oxygen patients who would have to find another provider, with no one local to provide for all those patients. While I may give you a number of statistics, the reality is I get to see the face of our patients on a daily basis, and it is not right what competitive bidding will do to these individuals. Unfortunately there are many Medicare beneficiaries who have no one to be their voice and quite honestly they do not understand all the intricacies of the different programs that affect them, so it

is up to us not only as suppliers to be their voice, but to also speak up on our own behalf. This is more than just some program on a piece of paper it is something that is tangible in how it will affect you, your family along with everyone else, that finds themselves in a situation where they need medical equipment. One of you may currently use a cpap machine for sleep apnea, and you currently get supplies from your supplier who you like dealing with and is convenient for you, under the competitive bidding program your supplier may not be a winning bidder and now you have to get your supplies from supplier an hour away, and who doesn't give you the service in which you are use to receiving. When you are the one who needs equipment and needing it immediately it becomes personal real quick.

"Competitive" Bidding Program Statistics

A total of 2.9 million eligible beneficiaries would be impacted in the first 10 markets. Excluding Puerto Rico during the next round one, the total is 2.6 million.

- A total of 4,529 suppliers currently serve the 10 markets. Excluding Puerto Rico, it is 4,127.
- A total of 1,335 contracts were awarded in Round One, representing an average 71% of all suppliers eliminated from participating in the program. This includes providers large and small.
- Due to the 71% elimination of suppliers, a corresponding average increase of 339% in the ratio of beneficiaries per supplier resulted. This will greatly overwhelm the patient referral system, reduce access to care and result in increased hospital stays since winning suppliers may be unable to handle the increased volume.
- A total of 223,900 beneficiaries on oxygen would be impacted.
- A total of 143,400 diabetics could be forced to switch providers and use a lower-quality glucose monitoring device.
- A total of 214,000 patients on tube feeding could be forced to switch providers, and the winning supplier list is likely too small to accommodate a large influx of transitioning patients.
- Of 133 referrals made to winning suppliers for various product categories in six CBAs:
    - Over half of referrals to contracted suppliers resulted in those suppliers turning down the order for various reasons related to their inability to service the patients.
    - Over 60% of referrals that were made to contracted suppliers resulted in those suppliers stating that they could not provide service in a timely manner (same-day as expected by referral agents.)
    - Over 50% of referrals could not be serviced due to contract supplier's inability to service patient's zip code or not answering the telephone at all.

Once again I want to thank you for your time and ask that you do not support the Competitive Bidding program, that you see what this program really is. It is government taking the beneficiaries right of choice away.

KHCA
Kansas Home Care Association • 2738 SW Santa Fe Drive • Topeka, Kansas 66614
785/478-3640 • Fax 785/286-1835 • khca@kshomecare.org • www.kshomecare.org

TO: Joint Committee on Home and Community Based Services Oversight

FROM: Jane Kelly, Executive Director, Kansas Home Care Association

Effects of Competitive Bidding on Durable Medical Equipment Access

November 8, 2010

On behalf of the Kansas Home Care Association, I appreciate this opportunity to make comments on the effects of the CMS Competitive Bidding Program on Durable Medical Equipment Access for our elderly, disabled and chronically ill population. The KHCA is a statewide trade association representing approximately 130 home health care and hospice agencies.

Durable medical equipment (DME) refers to a class of medical supplies. These supplies are reusable, used in the home, and used to help an illness or a symptom of an illness. Examples of DME include scooters, hospital beds and prosthetics.

Any medical supplies that must be thrown away are not covered. This includes things like bandages and catheters. Medicare makes few exceptions to this. If you are receiving treatment under the home health-care benefit however, some nondurable items may be covered as DME, and if you are diabetic, Medicare will cover lancets and test strips. Before Medicare will cover any DME, a doctor must declare the item medically necessary, writing a prescription or a certificate. In some cases, Medicare requires the doctor to perform tests or examinations before it will cover the item. In most cases, if the patient is being cared for through a Home Health Agency, the agency bills their intermediary for the DME. The supplier must be Medicare-certified.

The DMEPOS Competitive Bidding Program was mandated by Congress through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).The statute requires that Medicare replace the current fee schedule payment methodology for selected Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) items with a competitive bid process. The intent is to improve the effectiveness of the Medicare methodology for setting DMEPOS payment amounts, which will reduce beneficiary out-of-pocket expenses and save the Medicare program money while ensuring beneficiary access to quality items and services.

Home and Community Based
Services Oversight
Date: 11-8-10
Attachment: #4

Under the program, a competition among suppliers who operate in a particular Competitive Bidding Area (CBA) is conducted. Suppliers are required to submit a bid for selected products. Not all products or items are subject to competitive bidding. Bids are submitted electronically through a web-based application process and required documents are mailed. Bids are evaluated based on the supplier's eligibility, its financial stability and the bid price. Contracts are awarded to the Medicare suppliers who offer the best price and meet applicable quality and financial standards. Contract suppliers must agree to accept assignment on all claims for bid items and will be paid the bid price amount. The amount is derived from the median of all winning bids for an item.

Before I comment further, I would like to explain that Kansas City is the only metro area included in the competitive bid areas (CBA) for Kansas. At this point in time, the competitive bid program will only affect our agencies and their clients in that area. Most of our member agencies will not be affected by this.

We do however feel, as currently designed, this bidding program will lower quality and reduce access to care for seniors and people with disabilities. Moreover, it will *reduce* competition, eliminating up to 90 percent of home medical equipment businesses in any market area where it is implemented. Many of these practices are small businesses already struggling under the current economic recession.

This bidding program allows the government to selectively contract with only a small fraction of current homecare providers, forcing out DME companies that provide high-quality equipment or provide critical patient services. Competitive bidding, which would ultimately drive national reimbursement rates, ignores the critical role of services required to provide care to people in their homes. It will result in fewer resources for service-related activities that patients and physicians have come to expect, which allow people to remain in their homes. The program does not adequately account for providers' ability to serve a geographic market. The program will produce a bureaucratic, anti-competitive price-setting system that would be similar to a closed-model HMO and would have the effect of government-mandated consolidation in the homecare sector.

This is not the solution to Medicare's reform -- and it is certainly not the answer for patients and seniors.

Access: As the number of suppliers is reduced, beneficiaries could experience problems accessing quality equipment and services, especially by geographic area and over time. Lower payments to suppliers may reduce beneficiary access to high quality, brand name, and customizable equipment, and other effective supplies that are familiar to the patient. The CB program may not adequately protect against supplier unavailability and delayed response time, causing hospital discharge delays and/or more emergency department visits. The CB program may reduce the provision of various services on which beneficiaries rely to remain independent and prevent complications, such as patient evaluation, education, and training, and equipment customization, adjustment, and timely repair and maintenance.

Quality: Under dramatically lowered prices, suppliers may not be able to provide high quality products, and may significantly reduce the services they provide to beneficiaries. Suppliers may not be able to afford (and are not incentivized to provide) higher quality products, which can affect beneficiary mobility, general health condition, and quality of life. Technological innovation and development of high quality products may be stifled.

Delivery may further be impacted by restrictions on the competitive bidding product categories; whereas a supplier could increase efficiency by delivering multiple types of equipment, now they will only be able to deliver the product for which they won a contract. Response time is particularly important for patients being discharged from a hospital or skilled nursing facility who need prompt delivery in order to return home. Patients with long-term, chronic conditions, such as COPD, also need access to timely delivery in the event that their oxygen concentrator or other life-preserving equipment fails.
The legislation establishing the competitive bidding program does not articulate any specific patient safeguards relating to marketing, enrollment and disenrollment, benefit design, or quality standards – unlike the Medicare Part D program. Competitive bidding is so focused on price discounting that it provided the Secretary of DHHS the authority to pursue implementation of the program in the absence of quality standards. Supplier competition based on price, in the absence of beneficiary safeguards, may cause a significant decrease in the quality of both DMEPOS products and customer service.

Bids are not binding commitments. Companies are not bound by their bids. Any winner can decline to sign a supply contract following the bidding process. This undermines the credibility of bids and encourages low-ball bids in which the supplier acquires at no cost the option to sign a supply contract. This aspect of the current system has led to the predictable outcome where a number of bidders, realizing that prices were set below their costs, have refused to sign contracts.

Beneficiaries could also develop medical complications as a direct result of inadequate access to clinically appropriate equipment (e.g. pressure ulcers from improper seating cushions, hospitalization from fewer or irregular blood sugar testing, degradation of general health from lack of exercise due to mobility restrictions) that usually require more expensive medical care.

Vulnerable Medicare beneficiaries that use DMEPOS are often disabled or have long-term, chronic conditions. In the absence of a treatment to cure their conditions, clinically appropriate and properly fitted DMEPOS is often the best and most cost-effective medical intervention and preserves their ability to live independently. The results of DMEPOS provider competition based on price, rather than quality of supplies or customer service, may result in significant reductions to the quality of items and services beneficiaries need to remain at home, independently. Unintended consequences that could result include secondary medical complications, increased emergency department visits and hospital discharge delays, and ultimately, a transition out of the home to more costly facility-based care.

My name is Sara Sack. I am a Senior Research Professor at the University of Kansas and Director of the statewide assistive technology program, Assistive Technology for Kansans (ATK). ATK works with over 2,000 Kansans from every county in the state who have disabilities and health conditions. The twenty-six staff members at the six regional Assistive Technology Access Sites across the state provide demonstrations and evaluations to help individuals identify, try out, and acquire technology that will assist them in employment, education, and community living settings. ATK helps persons with disabilities locate the technology that will meet their individual circumstances and refers them to equipment suppliers but ATK does not vend assistive technology devices or durable medical equipment.

Assistive Technology for Kansan's close connections with individuals with disabilities and health conditions across the state, and concern regarding the competitive bidding process for purchasing Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) that many people with disabilities of all ages literally rely on for their lives, brings me here to speak with you today.

The "Findings of the 167 Economists", which included several Nobel Prize winners, shared with US Representative Pete Stark and the "Dobson DaVanzo & Associates Report", concluding that the competitive bidding process as currently designed will not produce the anticipated savings and will have negative effects on the marketplace and access to necessary equipment, are documents that you have previously studied. I am not here today to review those documents but to share concerns regarding the potential impact of competitive bidding in Kansas.

ATK's concerns include:

- Durable Medical Equipment Suppliers, especially small businesses, going out of business. Research on the Round 1 Durable Medical Equipment Competitive Bidding Program found that small businesses frequently submitted "suicide bids" in order to survive in the marketplace, although

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acknowledged that they would not be able to sustain these prices over the long-term.

- Loss of small businesses and employment opportunities in Kansas is and will be devastating to communities and to consumers.
- The economic "savings" from competitive bidding may not be as forecasted—fewer suppliers could eventually lead to less, nor more, price competition.
- Loss of durable medical equipment suppliers is bad for consumers. A reduction in the number of suppliers means that consumers may have to travel longer distances to obtain equipment or get their personal equipment repaired. Transportation is a major problem for this population and increased distances creates additional complications for persons with disabilities.
- A longer waiting period for equipment and repair puts Kansans at medical risk. Lack of access to medically prescribed equipment has been shown to increase falls and medical complications thus increasing use of physician care, emergency room, and extended hospital stays.
- Lack of access to durable medical equipment negatively impacts a person's ability to live independently and may result in increased institutionalizations for this population.
- Proposed "savings" from the competitive bidding process, especially for this population of persons with disabilities and significant health conditions, may in fact result in increased costs for other programs due to increased medical and care costs.
- The competitive bidding process as designed does not protect beneficiaries against difficulties in accessing equipment and necessary services. A bid winner may limit or discontinue delivery and rely on a pick-up or mail order delivery system. This presents significant barriers for individuals with acute health conditions and disabilities.
- Additionally, there is no requirement for response time, i.e, delivery time, within the competitive bidding process. To reduce costs suppliers could

reduce the frequency of deliveries thus further reducing beneficiaries timely access to necessary medical devices, products, and services.

- Persons with significant disabilities and health conditions often establish lifelong relationships with their suppliers and technicians who are familiar with their specific needs and care. Reducing the choice of suppliers jeopardizes these relationships and knowledge of the individual's complex health needs.
- Choice in terms of suppliers and equipment will be limited. Consumers may face changes in acquiring the brand, options, and flexibility of equipment and supplies that they have become familiar with and meet their individual needs.
- Durable medical equipment is not a "one size fits all" type of commodity that is easily interchangeable, but is often customized to fit the individual which further necessitates the need for a range of equipment and options. Access to appropriately fit technology prevents the development of complications such as pressure sores. A single hospitalization from pressure sores costs tens of thousands of dollars and can be life threatening.
- Before competitive bidding, consumers may have obtained all necessary services from a single supplier; under competitive bidding consumers may have to visit several suppliers in order to meet their needs thus increasing time, expense, and transportation barriers.

In summary, while Assistive Technology for Kansans applauds efforts to use healthcare dollars wisely, competitive bidding for durable medical equipment and services does not seem to be the recommended strategy—the potential negative impact is too great.

The shift from "allowable charges" for equipment and services from any "qualified provider" in Kansas to a selected provider, competitive bid process does not appear to be in the best interest of business, employment, or persons with disabilities in Kansas.

Cerebral Palsy Research Foundation of Kansas
(CPRF)

Testimony on the Effect of Medicare's Competitive Bidding Program on Access to Durable Medical Equipment

November 8, 2010

To: **Joint Committee on Home and Community Based Services Oversight**
From: **David Kemp, CPRF Vice-President of Technical Services, Daniel M. Carney Rehabilitation Engineering Center**

Good Morning, Chairperson Bethell and members of the Joint Committee on Home and Community Based Services Oversight, my name is David Kemp and I am the Vice-President of Technical Services at the Daniel M. Carney Rehabilitation Engineering Center which is a division of Cerebral Palsy Research Foundation (CPRF). I have been an occupational therapist for over 25 years and have specialized in recommending and customizing wheelchairs for the last 14 years. I want to thank you for allowing me the opportunity to speak to you about our concerns regarding the competitive bidding process and Medicare.

CPRF performed evaluations and custom fittings of wheelchairs for over 700 Kansans last year residing in over 80 counties. Our clients all have long-term chronic conditions which can include cerebral palsy, neuromuscular disease, multiple sclerosis, spinal cord injuries, spina bifida, chronic obstructive pulmonary disease, congestive heart failure, etc. In our opinion – there are many reasons to be concerned with the current competitive bidding process as it is now set-up by CMS.

The DME (or DMEPOS) providers are a critical member of our evaluation team. The occupational and physical therapists rely on the expertise of the DME provider when it comes to the individual equipment recommendations for each of our clients. CPRF uses four local DME providers who have years of experience. We are very careful about which DME providers we allow in our clinic. Each DME provider has a proven track record of providing the right equipment in a timely and thorough manner. They must be customer friendly and service the equipment they sell quickly and efficiently. Our DME providers also do much

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more than provide wheelchairs. They must know the unique rules and regulations for each third party payer. They coordinate all the documentation with the insurers and with the client's doctors. They order and inventory the wheelchair frames and individual seating components. They follow-up with each client and provide warranty work as needed. The few DME providers that we have are unique in that they have made the commitment to quality service not only to our clients but also to our clinic.

The competitive bidding process for Medicare has not come to Wichita Kansas yet. We have been watching with great interest the competitive bidding process that is happening now in Kansas City Kansas and Missouri. It is important to note that Medicare and CMS drive the entire industry of wheelchairs and seating. Kansas Medicaid often follows the structure and pricing that Medicare sets. This is also the case with insurances we deal with. We are sure that other presenters today will comment on the bidding process and the fairness and/or unfairness of the rules. We are not in a position to comment on that because CPRF is not a DME provider. We are going to outline our concerns on how this radical new payment system could potentially alter our ability to provide quality wheelchairs and seating systems to our clients.

It appears that competitive bidding will lead DME provider bid winners, to severely under bid the contracts for a given area so that they can continue to survive. A poll of current bid winners in the ten cities that currently have competitive bidding said that they "would meet the new prices by cutting services and providing less expensive – low quality equipment." The clients who we see in our clinic live in both rural and urban settings. Most of our clients live in their own homes or apartments and depend on their wheelchairs for all their mobility. Some have good access to public transportation – most do not. Many of the clients will drive their wheelchairs multiple miles each day. They drive to jobs, bus stops, schools, shopping centers, social events, etc. Medicare guidelines stipulate that only one wheelchair can be delivered to an individual client every five years. The wheelchairs have to be rugged and dependable or the client will more than likely be bed bound. Most of the wheelchairs we deliver are not like the ones you see on TV. Those wheelchairs are much too fragile to hold up to the daily grind of most of the clients who come to our clinic.

A report by George Washington University School of Public Health and Health Services argues that the competitive bidding process will dangerously narrow a client's access to products and "foster wholesale product substitution even when clinical customization may be essential". We already see this on occasion. Inappropriate wheelchairs often lead to pressure sores, repetitive joint injuries, pneumonias and other even more disabling conditions. Hospitalizations, nursing homes and other institutional care may also result. It is conceivable that even our clinic will be forced to recommend inappropriate wheelchairs because this is the only thing that a DME bid winner can afford to provide.

Our current DME providers have long-term relationships with our clients. They provide quality service on a timely basis. There is no provision in the new system outlining when a bid winner must provide service to their clients. I can't tell you how many times our clients break down in their wheelchairs because of the load they put on them daily. Many of our client's are bed bound until the needed repairs can be estimated, parts ordered, and service provided. Our current DME providers work hand in hand with us to assist our clients because it is the right thing to do – however they know if they don't the client will go to their competition. What will happen when there is only one provider in the area for wheelchairs? Will that bid winner really move quickly if there is no competitive recourse for their clients if they don't? Our current DME providers have told us that they can barely sustain their current level of service given what Medicare pays now. It stands to reason that our clients will see greatly reduced services if this system is adopted.

Medicare and Kansas Medicaid are the dominant payers of the wheelchairs we recommend. If Kansas Medicaid adopts such a system (without meaningful changes) then it is good bet that many of our high quality DME providers will have to close their doors. Other – less qualified – less knowledgeable DME businesses may step in to fill the void, thus damaging a proven network of providers.

The idea of pursuing cost reduction is admirable and needed but in our opinion the current competitive bidding process has serious consequences for disabled Kansans and the current provider network that serves them.

Thank you again, Chairperson Bethell and members of the Joint Committee on Home and Community Based Services Oversight for allowing me to testify on this very important issue.

KANSAS DENTAL ASSOCIATION

Date: November 8, 2010

To: Joint Committee on Home and Community Based Services Oversight

From: Kevin J. Robertson, CAE
Executive Director

RE: Oral Health Issues

Chairman Bethel and members of the committee I am Kevin Robertson, executive director of the Kansas Dental Association representing 1,250, or some 77% of the state's licensed dentists. Thanks for the opportunity to discuss with you the Kansas Dental Associations' thoughts on expanded function dental hygienists and dental access in general.

The Kansas Dental Association (KDA) believes it is essential that all Kansans have access to good oral health care. As such, the KDA is very interested in working with the members of the dental team to enhance and increase the care they provide to patients under various levels or dental supervision. In 2002, the KDA and Kansas Dental Hygienist Association hammered out the agreement that became the Extended Care Permit (ECP) Dental Hygienist. The KDA was also involved and supported changes to the ECP I and II legislation in 2007.

On the national level the American Dental Association (ADA), like other organizations is experimenting with different concepts of expanded dental team members and the pilot training for their Community Dental Health Coordinator (CDHC) dental team member concept is in its final stages. The CDHC is modeled after a community health worker, where a prospective CDHC is recruited from a local community, trained and then returned to provide oral health instruction, preventative and emergency services, and case management to individuals who may not be familiar with or intimidated by the healthcare experience. Following the completion of the pilot CDHC training at the University of Oklahoma, UCLA and Temple Schools of Dentistry a third party consultant will be asked to evaluate the effectiveness of the care and instruction patients receive in both rural and inner city settings. The KDA is very interested in the results of these findings that are approximately one year away.

The KDA believes strongly that prevention is the most cost effective and promising strategy to improve the oral health of Kansas citizens in all settings and the dental hygienist is the dental team prevention specialist. The KDA is exploring a concept that combines the work of the CDHC piloted by the ADA and expands upon our own Extended Care Permit (ECP) dental hygienists to create a dental community health worker of sorts. The concept would be to create a new level of ECP...an ECP III... whereby a dental hygienist would be required to complete some social work/counseling education regarding underserved populations as well as training on providing additional dental services. These dental services might include evaluation, temporary fillings and other emergency stabilization techniques. The ECP III would not perform surgical and diagnostic procedures, instead they would concentrate on

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preventative services, dental education, case management and emergency procedures to help change habits and get patients into a dental home with regular dental care. The KDA has a task force scheduled to meet on this issue on Friday and we are still working out the details of this concept. At this time we have not approached other groups formally about the concept.

The KDA believes that dentists with their education, training and experience are the best means to provide Kansans with diagnostic and surgical dental care that is second to none in the world. This can best be accomplished in Kansas by increasing the number of dental seats (by five or six per year) that Kansas has with UMKC (or another dental school) and tying those seats specifically back to underserved areas. We also believe it is time to look at the possibility of requiring all Kansas dental students at UMKC to return to Kansas for a certain number of years' service (probably four years) or be penalized as part of their dental school admission. The current agreement between Kansas and Missouri for dental seats is to be renewed in 2011 and there is a tremendous opportunity to look at both of these options. UMKC is also in the beginning stages of exploring the feasibility of locating a satellite campus with around 10 students in Kansas. This would be in addition to the 21 Kansas dental students per year currently educated on the UMKC School of Dentistry campus.

The KDA will also ask the legislature to again implement a dental student loan repayment bridging loan program that would provide an incentive for dental graduates to locate their practice in underserved areas. We are looking at possible funding options that would not require general fund expenditures.

Regardless of the number or type of provider...dentist, dental hygienists, or something else...getting people to seek dental treatment is a concern that requires all of our attention. Delta Dental Plan of Kansas is by far the largest dental insurance company in Kansas with 850,000 insured lives and a provider network that is 91% of all the dentists in the state. Most of you would agree that an employed Kansan with Delta Dental insurance has dental access, yet Delta reports that only about 50% of its dental insurance policy holders and their dependents see a dentist in a given year. For one reason or another, many Kansans do not see a dentist even when they have insurance that covers a substantial portion of the cost. Dental disease can be prevented. It will never be possible to "drill and fill" our way to better oral health for all Kansans and it would not be popular to legislate adults that should know better to brush their teeth on a regular basis or to brush and/or oversee their children brushing their teeth.

As this committee has discussed, about 26% of the practicing dentists in Kansas are active Medicaid providers. This is in spite of ongoing issues within Medicaid - a 10% reimbursement rate cut last year (since restored), discontinued funding of the Frail and Elderly, Pregnant Mothers and Developmentally Disabled HCBS waivers, with the exception of adjustments for the now nonexistent Frail and Elderly Program, a reimbursement rate of about 55% of actual dental fees on most procedures when dental office overhead averages around 60%, no overall rate increase since 1999 (regular inflation has increased 31% in that time), Medicaid dental provider support has been eliminated, and there is no one recruiting new dentists. In addition to these issues at times dentists have been asked to reimburse Medicaid $1,000s for simply filing claims as per standard ADA CDT procedure, and the provider agreement is 180 pages long! In general, the Medicaid process is so outside the norm for most dental offices it is challenging for many offices. There are also many past "horror" stories surrounding the program and most dentists choose to steer clear!

Recently, SRS thought it would be receiving Federal Stimulus money for an Urgent Dental Care Program to treat adults with dependent children. In August the KDA recruited 55-60 dental offices in a two week period to provide care at Medicaid rates prior to Sept. 30. Unfortunately 20-25 of these dentists were

turned away when it was later discovered that the program had not been approved and several dentists were told "they were not needed" or "no one needed care" in their area. This was not Medicaid, but it does show that dentists are willing to provide care even at lower rates without the burdens of the government bureaucracy when called upon.

Having said all this, the KDA is very interested in improving Kansas Medicaid to make it a more workable model for dentists and Medicaid recipients. The KDA is investigating the possibility committing resources to building the provider network to 50% or more if certain changes in the administration of dental Medicaid are made. This might include streamlining the provider contract and claims processing, the types of claims reimbursed, rates, etc. I again apologize for not having a specific proposal at this time.

Currently, the dentists of Kansas fund, administer and support two programs for adult dental care in Kansas through the Donated Dental Services (DDS) program and the Kansas Mission of Mercy (KMOM). After the Kansas Health Policy Authority (KHPA) cut funding in 2009 to the DDS program after 13 years of support, private grants and personal funding by dentists have been raised to continue it through FY 2011. What will happen to the DDS program in FY 2012 is unknown. DDS' 350 dental providers complete approximately $500,000 in free dental care each year to disabled and elderly patients. The administrative cost of this program is $70,000. The annual KMOM free dental clinic administer by the KDA's own Kansas Dental Charitable Foundation (KDCF) consistently provides about 1,700 patients with around $1 million in free dental care per year. KMOM has never received a government grant or tax-based support with the exception of local law enforcement or government facilities that from time to time are donated for the event. It costs approximately $60,000 annually to put on a KMOM event. In all, the nine KMOMs have provided care to 17,500 patients totaling $8.5 million. Nearly half of the dentists in Kansas have participated in at least one KMOM event. It is estimated that the average dentist provides **$33,000** in charity and reduced-fee care to patients every year. That comes to **$46.3 million** in free and reduced care ANNUALLY given by Kansas Dentists to the people of Kansas!

Thank you for the opportunity to appear before you today. I would be happy to answer any questions at this time.

American
Dental
Hygienists'
Association

[illegible]
[illegible]
Topeka, KS [illegible]
www.KDHA.org

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Joint Committee on Home and Community Based Services Oversight
On Expansion of Scope of Practice for Dental Hygienists
Testimony of Maggie Smet, RDH
Kansas Dental Hygienists' Association President, 2010-2011
November, 8, 2010

Thank you Mr. Bethell and to the Committee for this opportunity to address you regarding the scope of practice of dental hygienists' in the state of Kansas. I am Maggie Smet a Registered Dental Hygienist with 20 years of clinical experience. I was recently installed for a third term as President for the Kansas Dental Hygienists' Association. I am also the very first Extended Care Permit (ECP) provider.

Kansas currently has approximately 1739 Registered Dental Hygienists licensed in our state. Kansas has five accredited dental hygiene programs which graduate a total of approximately 99 students yearly. Kansas also has about 1430 dentists practicing, of which none were educated in our state due to the lack of a dental school in our state. No matter how many dental practitioners we have in our state, it is absolutely clear that our current oral health delivery model is not reaching all Kansans. This is particularly troublesome, because we have the ability to significantly improve access to oral health care.

Our discussion today is about the expansion of scope of practice for dental hygienists. The current scope of practice is determined by the Kansas Dental Practice Act. In 2002, the Kansas Dental Association and the Kansas Dental Hygienists' Association (KDHA) collaborated on legislation that was passed in 2003. The new law gave dental hygienists licensed in the State of Kansas an "Extended Care Permit" I or II (ECPI/II) and the opportunity to provide preventive services without direct supervision of a dentist. The ECP hygienists have a sponsoring dentist who monitors his/her activity through a written arrangement and review of patient records. In addition patients did not have to be a "patient-of-record" of a specific dentist in order to receive services. The ECP I/II can be used in community settings, such as Head Start programs, schools, local health departments, safety net clinics, long-term care facilities, on persons with developmental disabilities and on persons who are 65 years and older who live in a residential center, subsidized housing, hospital long-term care unit, state institution or are served in a community senior service center, elderly nutrition program or at the home of a homebound person who qualifies the federal home and community based service (HCBS) waiver.

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The overall purpose of Extended Care Permit (ECPI/II) hygiene services is to provide prevention and early identification of oral health services to Kansas residents who go without any dental services due to costs, transportation, and/or oral health knowledge.

In 2007, the Kansas Legislature passed amended legislation that allowed the ECP hygienists to serve additional populations in community settings. (HB2214) Due to this legislation, many Kansans receive their preventive dental care from an ECP dental hygienist without first having to become a patient of record of a dentist.

Right now, approximately 127 Kansas dental hygienists hold an Extended Care Permit (ECP) These ECP dental hygienists primarily work in conjunction within one of 19 Safety Net Dental Clinics in Kansas. Many successful ECP programs exist and deliver dental hygiene care to Kansans outside a dental office that would not otherwise have an opportunity to see a dental professional. KDHA continues to educate dental hygienists on the Extended Care Permit to increase the number of permits to provide preventive oral health care for those so desperately in need.

Some barriers exist that easily prevent any dental hygienist from starting up an Extended Care Permit program outside a Safety Net Dental Clinic. A few of these barriers are:

*High cost of mobile dental equipment and supplies

*Inability to bill a third party (such as Medicaid) and receive direct reimbursement (Current statutes provide that the ECP dental hygienist may only be paid by the sponsoring dentist or a participating not-for-profit organization)

*Difficulty in finding a dentist to refer needed restorative work

*Salary difference between working with Medicaid eligible patients vs. HCBS clients who have no funding for preventive dental care.

*start up Frame work in place as well as current statutes and education, but sustaining funding is compromised.

Example of funding:

Infants and toddlers 0-3yrs: fluoride varnish application only. (Not sustainable)

Age 3-21 is good=Medicaid

Age 21 and over, no preventive service reimbursement

Safety Net Dental Clinics are an underutilized source for the dentally underserved. Each clinic has the ability to utilize ECP dental hygienists as "spokes- to- their- hub" with outreach preventive services extending in the community and outlying communities. Recruiting and retaining a public health dentist can be a challenge, primarily because there is a general shortage of dentists in many parts of the state and many are reluctant to forego the advantages of private practice.

The underserved community in Kansas is growing. The population of dentists is decreasing. Kansas should consider development and implementation of a mid-level professional who can extend the reach of traditional dentistry into our underserved communities. The likelihood that we will ever be able to satisfy our unmet oral health needs with traditional dentists is remote at best. But the cost of not meeting those needs is enormous. The health and productivity of thousands of Kansans is diminished by oral health disease and the quality of life for many of our seniors is tragically shortchanged. This is all because we are locked into a delivery system that doesn't work for all Kansans.

In closing, the Kansas Dental Hygienists' Association urges the Kansas Legislature to support enhancements to the current ECP legislation to allow these preventive oral care providers to access more easily access those populations in need, and to consider implementation of a new mid-level oral health practitioner who can help fill the enormous gaps in access to oral health care.

Thank you.

**For further reference:

Extended Care Permit Statute:

65-1456

Chapter 65.--PUBLIC HEALTH
Article 14.--REGULATION OF DENTISTS AND DENTAL HYGIENISTS
65-1456. Dental hygienists; suspension or revocation of licenses, when; notice and hearing; practice of dental hygiene defined; rules and regulations; supervision

defined; where performance of practice authorized, issuance of permits therefor; authorized activities, requirements. (a) The board may suspend or revoke the license of any dentist who shall permit any dental hygienist operating under such dentist's supervision to perform any operation other than that permitted under the provisions of article 14 of chapter 65 of the Kansas Statutes Annotated, or acts amendatory thereof, and may suspend or revoke the license of any hygienist found guilty of performing any operation other than those permitted under article 14 of chapter 65 of the Kansas Statutes Annotated, or acts amendatory thereof. No license of any dentist or dental hygienist shall be suspended or revoked in any administrative proceedings without first complying with the notice and hearing requirements of the Kansas administrative procedure act.

(b) The practice of dental hygiene shall include those educational, preventive, and therapeutic procedures which result in the removal of extraneous deposits, stains and debris from the teeth and the rendering of smooth surfaces of the teeth to the depths of the gingival sulci. Included among those educational, preventive and therapeutic procedures are the instruction of the patient as to daily personal care, protecting the teeth from dental caries, the scaling and polishing of the crown surfaces and the planing of the root surfaces, in addition to the curettage of those soft tissues lining the free gingiva to the depth of the gingival sulcus and such additional educational, preventive and therapeutic procedures as the board may establish by rules and regulations.

(c) Subject to such prohibitions, limitations and conditions as the board may prescribe by rules and regulations, any licensed dental hygienist may practice dental hygiene and may also perform such dental service as may be performed by a dental assistant under the provisions of K.S.A. 65-1423 and amendments thereto.

(d) Except as otherwise provided in this section, the practice of dental hygiene shall be performed under the direct or general supervision of a licensed dentist at the office of such licensed dentist. The board shall designate by rules and regulations the procedures which may be performed by a dental hygienist under direct supervision and the procedures which may be performed under general supervision of a licensed dentist. As used in this section: (1) "Direct supervision" means that the dentist is in the dental office, personally diagnoses the condition to be treated, personally authorizes the procedure and before dismissal of the patient evaluates the performance; and (2) "general supervision" means a Kansas licensed dentist may delegate verbally or by written authorization the performance of a service, task or procedure to a licensed dental hygienist under the supervision and responsibility of the dentist, if the dental hygienist is licensed to perform the function, and the supervising dentist examines the patient at the time the dental hygiene procedure is performed, or during the 12 calendar months preceding the performance of the procedure, except that the licensed hygienist shall not be permitted to diagnose a dental disease or ailment, prescribe any treatment or a regimen thereof, prescribe, order or dispense medication or perform any procedure which is irreversible or which involves the intentional cutting of the soft or hard tissue by any means. A dentist is not required to be on the premises at the time a hygienist performs a function delegated under part (2) of this subsection.

(e) The practice of dental hygiene may be performed at an adult care home, hospital long-term care unit, state institution, local health department or indigent health care clinic on a resident of a facility, client or patient thereof so long as:

(1) A licensed dentist has delegated the performance of the service, task or procedure;

(2) the dental hygienist is under the supervision and responsibility of the dentist;

(3) either the supervising dentist is personally present or the services, tasks and procedures are limited to the cleaning of teeth, education and preventive care;

(4) the supervising dentist examines the patient at the time the dental hygiene procedure is performed or has examined the patient during the 12 calendar months preceding performance of the procedure; and

(f) The practice of dental hygiene may be performed with consent of the parent or legal guardian, on children participating in residential and nonresidential centers for therapeutic services, on all children in families which are receiving family preservation services, on all children in the custody of the secretary of social and rehabilitation services or the commissioner of juvenile justice authority and in an out-of-home placement residing in foster care homes, on children being served by runaway youth programs and homeless shelters; and on children birth to five and children in public and nonpublic schools kindergarten through grade 12 regardless of the time of year and children participating in youth organizations, so long as such children birth to five, in public or nonpublic schools or participating in youth organizations also meet the requirements of medicaid, healthwave, or free or reduced lunch programs or Indian health services; at any state correctional institution, local health department or indigent health care clinic, as defined in K.S.A. 65-1466, and amendments thereto, and at any federally qualified health center, federally qualified health center look-alike or a community health center that receives funding from section 330 of the health center consolidation act, on a person, inmate, client or patient thereof and on other persons as may be defined by the board; so long as:

(1) The dental hygienist has received an "extended care permit" from the Kansas dental board specifying that the dental hygienist has performed 1,200 hours of dental hygiene care within the past three years or has been an instructor at an accredited dental hygiene program for two academic years within the past three years;

(2) the dental hygienist shows proof of professional liability insurance;

(3) the dental hygienist is sponsored by a dentist licensed in the state of Kansas, including a signed agreement stating that the dentist shall monitor the dental hygienist's activities, except such dentist shall not monitor more than five dental hygienists with an extended care permit;

(4) the tasks and procedures are limited to: (A) removal of extraneous deposits, stains and debris from the teeth and the rendering of smooth surfaces of the teeth to the depths of the gingival sulci; (B) the application of topical anesthetic if the dental hygienist has completed the required course of instruction approved by the dental board; (C) the application of fluoride; (D) dental hygiene instruction; (E) assessment of the patient's apparent need for further evaluation by a dentist to diagnose the presence of dental caries and other abnormalities; and (F) other duties as may be delegated verbally or in writing by the sponsoring dentists consistent with this act;

(5) the dental hygienist advises the patient and legal guardian that the services are preventive in nature and do not constitute a comprehensive dental diagnosis and care;

(6) the dental hygienist provides a copy of the findings and the report of treatment to the sponsoring dentist and any other dental or medical supervisor at a participating organization found in this subsection; and

(7) any payment to the dental hygienist for dental hygiene services is received from the sponsoring dentist or the participating organization found in this subsection.

(g) The practice of dental hygiene may be performed on persons with developmental disabilities and on persons who are 65 years and older who live in a residential center, an adult care home, subsidized housing, hospital long-term care unit, state institution or are served in a community senior service center, elderly nutrition program or at the home of a homebound person who qualifies for the federal home and community based service (HCBS) waiver on a resident of a facility, client or patient thereof so long as:

(1) The dental hygienist has received an "extended care permit II" from the Kansas dental board specifying that the dental hygienist has: (A) performed 1,800 hours of dental hygiene care or has been an instructor at an accredited dental hygiene program for two academic years within the past three years; and (B) completed six hours of training on the care of special needs patients or other training as may be accepted by the board;

(2) the dental hygienist shows proof of professional liability insurance;

(3) the dental hygienist is sponsored by a dentist licensed in the state of Kansas, including a signed agreement stating that the dentist shall monitor the dental hygienist's activities, except such dentist shall not monitor more than five dental hygienists with an extended care permit II;

(4) the tasks and procedures are limited to: (A) removal of extraneous deposits, stains and debris from the teeth and the rendering of smooth surfaces of the teeth to the depths of the gingival sulci; (B) the application of topical anesthetic if the dental hygienist has completed the required course of instruction approved by the dental board; (C) the application of fluoride; (D) dental hygiene instruction; (E) assessment of the patient's apparent need for further evaluation by a dentist to diagnose the presence of dental caries and other abnormalities; and (F) other duties as may be delegated verbally or in writing by the sponsoring dentist consistent with this act;

(5) the dental hygienist advises the patient and legal guardian that the services are preventive in nature and do not constitute comprehensive dental diagnosis and care;

(6) the dental hygienist provides a copy of the findings and the report of treatment to the sponsoring dentist and any other dental or medical supervisor at a participating organization found in this subsection;

(7) any payment to the dental hygienist for dental hygiene services is received from the sponsoring dentist or the participating organization found in this subsection; and

(8) the dental hygienist completes a minimum of six hours of education in the area of special needs care within the board's continuing dental education requirements for relicensure.

(h) In addition to the duties specifically mentioned in subsection (b) of K.S.A. 65-1456, and amendments thereto, any duly licensed dental hygienist may:

(1) Give fluoride treatments as a prophylactic measure, as defined by the United States public health service and as recommended for use in dentistry;

(2) remove overhanging restoration margins and periodontal surgery materials by hand scaling instruments; and

(3) administer local block and infiltration anaesthesia and nitrous oxide. (A) The administration of local anaesthesia shall be performed under the direct supervision of a licensed dentist except that topically applied local anaesthesia, as defined by the board, may be administered under the general supervision of a licensed dentist. (B) Each dental hygienist who administers local anaesthesia regardless of the type shall have completed courses of instruction in local anaesthesia and nitrous oxide which have been approved by the board.

(i) (1) The courses of instruction required in subsection (h)(3)(B) shall provide a minimum of 12 hours of instruction at a teaching institution accredited by the American dental association.

(2) The courses of instruction shall include courses which provide both didactic and clinical instruction in: (A) Theory of pain control; (B) anatomy; (C) medical history; (D) pharmacology; and (E) emergencies and complications.

(3) Certification in cardiac pulmonary resuscitation shall be required in all cases.

(j) The board is authorized to issue to a qualified dental hygienist an extended care permit or extended care permit II as provided in subsections (f) and (g) of this section.

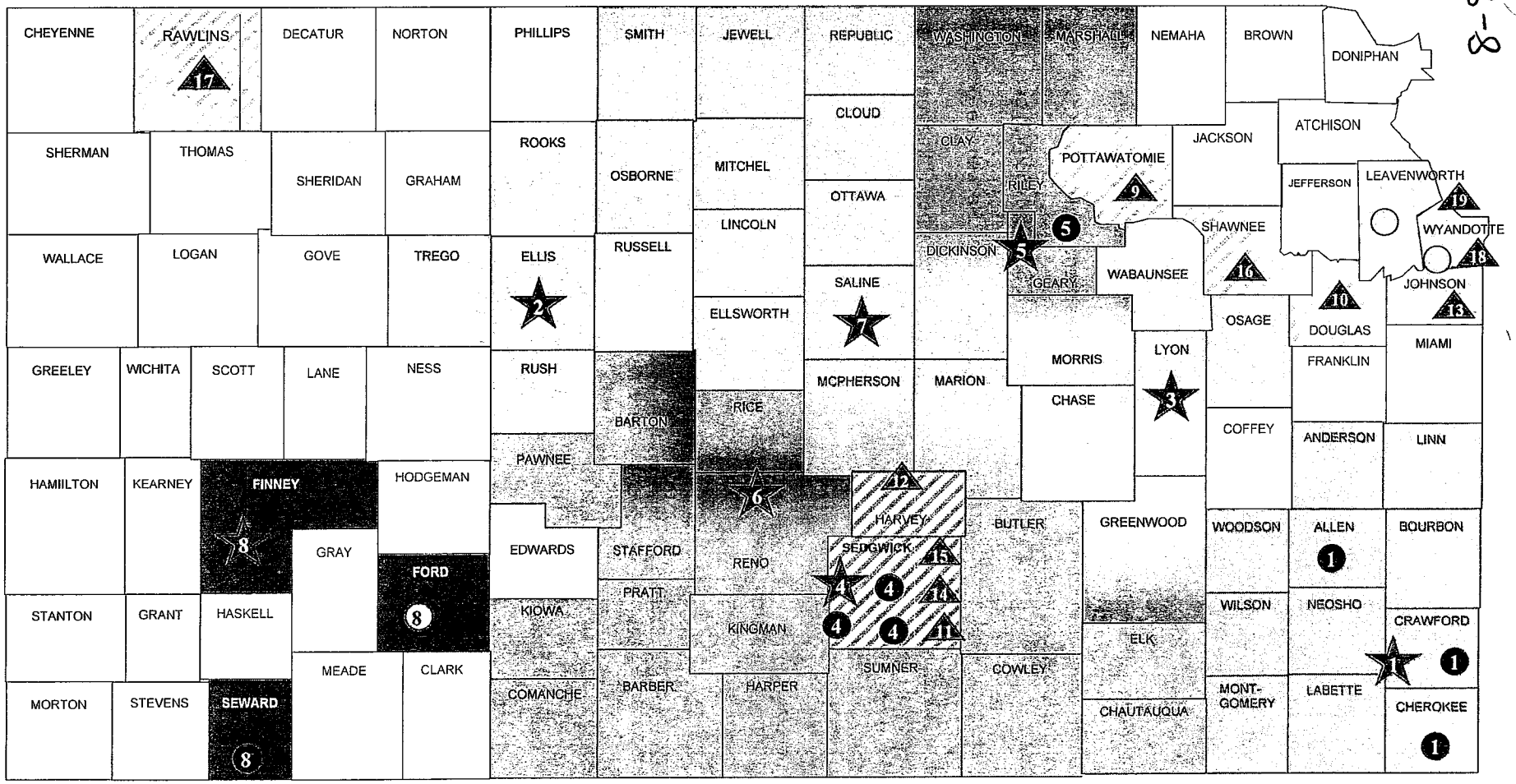
(k) Nothing in this section shall be construed to prevent a dental hygienist from providing dental hygiene instruction or visual oral health care screenings or fluoride applications in a school or community based setting regardless of the age of the patient.

History: L. 1943, ch. 221, § 40; L. 1976, ch. 269, § 1; L. 1984, ch. 313, § 103; L. 1996, ch. 210, § 4; L. 1997, ch. 30, § 3; L. 1998, ch. 141, § 2; L. 2000, ch. 169, § 13; L. 2001, ch. 155, § 3; L. 2003, ch. 125, § 1; L. 2007, ch. 134, § 4; July 1.

ECP Regulations:

71-3-9. Extended care permits. (a) Definitions.
(1) "Extended care permit I" shall mean a permit issued pursuant to K.S.A. 65-1456(f), and amendments thereto.
(2) "Extended care permit II" shall mean a permit issued pursuant to K.S.A. 65-1456(g), and amendments thereto.
(3) "Extended care permit treatment" shall mean the treatment that a hygienist may provide if the hygienist has a valid extended care permit I or II.
(4) "Patient assessment report" shall mean the report of findings and treatment required by K.S.A. 65-1456(f)(6) or (g)(6), and the amendments thereto.
(5) "Sponsoring dentist" shall mean a dentist who fulfills the requirements of K.S.A. 65-1456(f)(3) or (g)(3), and amendments thereto.
(b) Application for permit. Each applicant for an extended care permit I or II shall file with the board a completed application on a form provided by the board.
(c) Notice of practice location to sponsoring dentist. Before provided extended care permit treatment at a new location, each hygienist shall inform the sponsoring dentist, orally or in writing, of the new address and the type of procedures to be performed there.
(d) Patient assessment reports.
(1) Each required patient assessment report shall include a description of the extended care permit treatment, the date or dates of treatment, and the hygienist's assessment of the patient's apparent need for further evaluation by a dentist.
(2) No later than 30 days from the date on which extended care permit treatment is completed, the hygienist providing the treatment shall cause the required patient assessment report to be delivered to the sponsoring dentist.
(3) When providing extended care permit treatment at a location operated by an organization with a dental or medical supervisor, the dental hygienist providing the extended care permit treatment shall also cause the required patient assessment report to be delivered to the dental or medical supervisor within 30 days from the date on which the extended care permit treatment is completed.
(e) Suspension of extended care permit treatment. If a hygienist's sponsoring dentist cannot or will not continue to function as a sponsoring dentist, the hygienist shall cease providing extended care permit treatment until the hygienist obtains a written agreement with a replacement sponsoring dentist.
(f) Review of patient assessment reports. A sponsoring dentist shall review each patient assessment report within 30 days of receiving the report. (Authorized by K.S.A. 74-1406(e); implementing K.S.A. 2003 Supp. 65-1456; effective Sept. 17, 2004.)

Kansas Safety Net Dental Clinics, Dental Hubs, and Spokes



Clinics receiving Dental Hub funding from the State and/or Private Foundations

1. Community Health Center of Southeast Kansas
2. First Care Clinic
3. Flint Hills Community Health Center
4. GraceMed Dental Clinic & Spokes
5. Konza Prairie Community Health Center & Spokes
6. PrairieStar Health Center
7. Salina Family Health Care Center
8. United Methodist Mexican-American Ministries, Inc.

Other Safety Net Dental Clinics

9. Community Health Ministry Clinic
10. Douglas County Dental Clinic
11. E.C. Tyree Health & Dental Clinic
12. Health Ministries Clinic
13. Health Partnership of Johnson County
14. Healthy Options for Kansas Communities
15. Hunter Health Clinic
16. Marian Dental Clinic
17. Rawlins County Dental Clinic
18. Southwest Boulevard Family Health Care
19. Swope Health Wyandotte and Swope Health West

★ Existing Hub
Counties shaded surrounding dental hubs show areas that ECP hygienist are providing or will provide screenings and other services through portable outreach programs.

● Existing Spoke

○ Planned Spoke

▲ Safety Net Dental Clinic

3/12/10

Joint committee on Home and Community Based Services Oversight

On Expansion of Scope of Practice for Dental Hygienists

Testimony of Doreen Eyler, RDH

Extended Care Permit Hygienist

Dental Hygiene Lead at GraceMed

November 8, 2010

Thank you Representative Bethell and to the Committee for this opportunity to address you about Kansas dental hygienists scope of practice. I am Doreen Eyler, a Registered Dental Hygienist with 30 years of clinical experience. December 2005 I began working with GraceMed in Wichita, Kansas, as an extended care permit hygienist.

GraceMed is one of the 19 Safety Net Clinics that Maggie Smet described. We are a Federally Qualified Health Center providing both medical and dental care for the people of Wichita, Sedgwick County and Kansas. We treat the uninsured, the underinsured and the insured. We accept Medicare, Health Wave and commercial insurances. Those without insurance are charged according to a sliding fee scale. As a whole, the four GraceMed clinics provide medical and dental treatment with testing for more than 46,000 patient visits per year.

As Maggie Smet stated, before extended care Hygienists were given this permit to provide prevention and early identification services to Kansas residents, many went without dental care due to lack of money, transportation and/or oral health knowledge. GraceMed employs five full time dental Hygienists with Extended Care Permits (ECP) II and two PRN Extended Care Permit II Dental Hygienists to work not only in the clinical settings but also in our outreach program where we help with access to care in Kansas.

The sponsoring dentists required for ECP Hygienists are the dentists employed by GraceMed.

Home and Community Based Services Oversight
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ECP I serve children who qualify for Medicaid, HealthWave or free and reduced lunch programs, also children at Head Start and other early education settings, foster care, therapeutic centers, schools, community youth programs, local health departments, juvenile justice programs, and safety net clinics.

Hygienists with an ECP II serve a wider range of elders and adults with special health care needs. Those at individual and group homes, developmental disabilities centers, community subsidized house and meal programs, senior centers, long term care facilities, as well as the local health departments and safety net clinics.

GraceMed ECP II Hygienists travel a 60 mile radius around Wichita, five days a week, 52 weeks a year without our dentists being physically with us. The portable dental delivery system equipment and needed supplies used to perform patient care within the wide variety of facilities visited are transported in a GraceMed van.

Access to care for children is a dilemma found not only in the rural areas of Kansas but also in Wichita. Access to care can mean: no transportation to an affordable dentist or not being able to determine how to afford care that is needed. Prevention is ultimately the most important message we can spread to our high risk populations, as well as giving them access to dental prophylaxis, fluoride varnish and possibly sealants.

Each school child receives a screening report that informs the parent or guardian that their child received an ECP service. ECP I and II Hygienists cannot diagnose but can screen oral health conditions, inform parents/guardians of obvious dental concerns and refer to dental professionals for needed care. As a result, many of these schools are seeing positive screening reports on the children who have received sealants and fluoride three to four times from previous visits.

Referring is the most challenging part of our job. We visit areas where the family may have to drive up to two hours for affordable dental care. The cost of gas and time off from work are often enough to stop a family from finding help. Time away from the classroom also creates a negative impact. We see children who attend class in pain, lose sleep because of dental pain and are

malnourished due to painful chewing. We visit these schools once a year. There are children with small defects that could easily be relieved with a non-intrusive restorative appointment as opposed to the defect getting larger and spreading to the adjoining teeth. Parents often think that dental pain will subside if you tough it out. On occasion, GraceMed ECP Hygienists guide the school nurse and family into care with a family physician who can prescribe an antibiotic for an oral infection to buy time for an out of town dental appointment. We promote the importance of primary dentition along with prevention.

Along with serving Head Starts, schools and daycares, we provide ECP II services to long-term care facilities, persons with developmental disabilities, persons who are 65 years and older who live in residential centers and homebound persons who qualify for the Federal Home and Community Based Service (HCBS) waiver.

This population has transportation and financial issues when it comes to answering their access to care needs. GraceMed visits seven nursing homes, three senior centers and one homebound patient who qualifies for the HCBS waiver.

The senior centers are in partnership with their specific county's Area on Aging Council. Often the Area on Aging Council receives a grant that will help pay for a portion of the preventive appointment with the ECP Hygienists. Adult prophylaxis, fluoride treatment and oral health instruction are provided to each adult during their appointment at the senior center. Concerns are often in reference to an ill fitting denture/partial, broken fillings and/or gum line decay causing sensitivity and difficulty in chewing. Senior citizens with dental insurance prior to retirement find that following retirement, a fixed income and no dental insurance prevents the upkeep of necessary, expensive dental work. Health histories have changed and expensive prescriptions have become priority. Denture/partial repair, crowns to repair large broken restorations and repair of recurrent decay around existing restorations are the most expensive treatments, out of reach for most senior citizens. A portion of this population qualifies for a medical card which allows for an emergency exam, x-ray and extraction. Although providing relief of pain, does not provide an adequate

answer for replacing teeth to aid proper chewing, thereby providing proper nutrition. Referral to a safety net clinic for access to care with a sliding fee scale allows smaller payments for dental services. Please refer to Maggie Smet's map of safety net clinics.

Finding affordable dentistry and transportation to Wichita from 60 miles away is challenge due to the driving skills of senior citizens often diminishing in uncharted territory. Driving to Wichita or a neighboring city can be prohibitive. We partner them with the senior center driver to keep appointments. Each time we provide recare appointments to these senior centers, the defects in dentition and ill fitting dentures/partials has gotten worse and no restorative care has been sought. Supplying this population with oral health education and prevention is a main concern for our GraceMed outreach team.

Seven nursing home facilities value our preventive services, finding a small decrease in bacterial pneumonia in their patients. Barriers with access to care include financial, transportation and the patient's physical ability to receive ECP services. We bring our portable dental delivery system to the nursing home including our patient chairs. This enables preventive dental care to be provided while sitting in their wheelchair and/or bed. As a result, tasks such as wiping the food out of the folds of their mouth, cleaning dentures/partials or a full dentition requiring prophylaxis and fluoride treatment to be accomplished easily and more comfortable. GraceMed bills the nursing home for the total cost of the ECP visit and in return the nursing home bills the patient's guardian.

One week prior to visiting the facility, nurses fax the patients' health history to our supervising dentist at GraceMed. He reviews them allowing time for communication of any concerns with preventive services being provided to the residents. During treatment of the resident we often bring in the CNA's and/or nurse to assist with explaining the dental instructions needed to improve the patient's oral health care in a daily routine. Sometimes all it takes is to demonstrate the most effective method of assisting someone in holding a toothbrush.

Return visits become frustrating for ECP's when the care provided to the patient's oral health is diminished due to limited continuous care. Issues still

exist and frequently are worse. Getting a nursing home patient to dental care is difficult. We use our dental education and supervising dentist to determine the benefit of providing limited care vs. moving the patient to a dental care facility.

The value of preventive dentistry can not be overlooked. Total health preservation demands the value be acknowledged. As more elderly persons enter nursing home care with their own teeth, the potential for oral health problems and systemic illnesses increase. Nursing home residents often have a brittle health history. Keeping good health in check relies heavily on consistent oral health practices. For instance, research has emerged suggesting the relationship between periodontal disease and diabetes is relative. Periodontal disease may increase the difficulty for people with diabetes to control their blood sugar. The study published in Diabetes Care found that while 90% of nursing home residents with diabetes had their blood glucose levels monitored, only 38% met short-term glucose goals.

Studies also show that the presence of periodontal diseases, the diseases most common in people with tooth loss, actually affects longevity. The best of these studies done at Emory University with the Centers for Disease Control, indicated that people with gingivitis and periodontitis have a mortality rate that is 23 percent to 46 percent higher than those who don't. This is linked to increased rates of cardiovascular disease and stroke, as well as to an increase in mortality from other causes, such as infections. These studies prove without a shadow of a doubt that as long as the head is connected to the body, we need to take care of a person's total health from head to toe.

For the nursing home patients, 50% suffer from gum line decay caused from having a dry mouth. There are over 400 drugs on the market that cause xeristomia (dry mouth syndrome). If the gum line decay is not addressed when it is small, it spreads causing weakness in the tooth structure, and ending when the tooth breaks off at the gum line, like a tree being chopped down. It leaves a very sharp tooth structure to cause ulcers on the soft tissue and tongue, not to mention the sensitivity to temperature and sweets. As an Extended Care Permit Hygienist, I can administer fluoride varnish for sensitivity and a screening report for the nursing home and guardian to encourage a dental visit.

While we are in a nursing home we provide services for denture and partial cleanings. The resident comes to the temporary dental clinic and receives soft tissue screening along with a good wash of the removable appliances. Initially, the patient comes to us with a somewhat loose fitting appliance but is making it work with adhesive such as Fixodent. At the six month visit, the loose fitting appliance has more difficulty maintaining placement, even when adhesives are applied. The situation progresses to the removable appliance not being worn because it no longer fits and generally can't be found. The patient's nutrition is now a soft diet and their health as well as depression slides downward. Financially, the resident's guardian may actually allow for dental help, however transporting the resident to a dental care facility is often difficult. In Wichita, GraceMed has a good working relationship with many of the nursing homes with regard to getting the patient to and from our safety net clinic.

GraceMed employs three full time dentists and two part time dentists. GraceMed Dental Clinic schedules are consistently full. GraceMed ECP hygienists are doing full time outreach and providing clinical hygiene to manage the high demand for preventive services. We navigate our Kansas population through their health/dental needs along with spreading the word about prevention.

OUTREACH SITES

2010-2011 school year

In the last year, we have provided our Extended Care Permit Hygiene services to:

17 Counties throughout Kansas

Elk Sedgwick
Butler Sumner
Pawnee Harvey Marion
Mcpherson Rice Barton
Kiowa Reno Greenwood
Cowley Chatauqua Harper

Within these 17 counties we have visited

Schools

- 93 Elementary, Middle and High Schools.
  - **17 schools we provided screenings only, approximately 15,694 students**
  - **76 schools we provided cleanings and either screenings or sealants**

Nursing Homes

- 6 Nursing Homes / Senior Centers

Group Homes

- Both Lakeside and Riverside Camelot, 2-4 times a year

Head Starts/Preschools

- 11 Child Start locations in Wichita, providing services 3 times a year
- 20 other Head Starts / Preschools throughout Wichita and other surrounding areas

Special Needs Facilities

- Rainbows United, Wichita
- Bridges to Learning, Harper

ORAL HEALTH KANSAS

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KDHE, Bureau of Oral Health

Joint Committee on Home and Community Based Services Oversight
November 8, 2010

Chairman Bethell and members of the Committee, thank you for the opportunity to talk with you today about Extended Care Permits for Dental Hygienists. My name is Tanya Dorf Brunner, and I am the Executive Director of Oral Health Kansas. We are a statewide advocacy organization that promotes the importance of lifelong dental health by shaping policy and educating the public so Kansans know that all mouths matter.

In 2003 the Legislature established Extended Care Permits (ECP) for Kansas dental hygienists to be able to provide hygiene services for low-income children and adults in community health centers and prisons. The law was revised in 2007 to expand the scope of practice to community-based services for people with developmental disabilities and elderly people. KSA 65-1456, f-g

Twenty-eight other states have similar statutes allowing hygienists to practice outside the traditional dental office without a dentist present. The goal of the Kansas ECP law is to provide access to dental hygiene services to populations that are particularly underserved.

Kansas Dental Workforce Study

The KDHE Bureau of Oral Health published a Kansas dental workforce study in 2009. This study included a comprehensive look at ECP hygienists. Two-thirds of the ECP hygienists surveyed said they sought their ECP permit in order to help serve underserved populations. Eighty percent of the respondents said they are working at least a few hours a week as an ECP hygienist, and 38 percent reported they are not using their ECP permit to the extent they would prefer.

The workforce study also asked respondents what barriers they faced to beginning their ECP practice. The barriers they noted related primarily to the business aspects of beginning an ECP practice. *(See page 2 for the barriers.)*Anecdotally, ECP hygienists report similar challenges today, unless they practice within a community health center.

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Home and Community Based
Services Oversight
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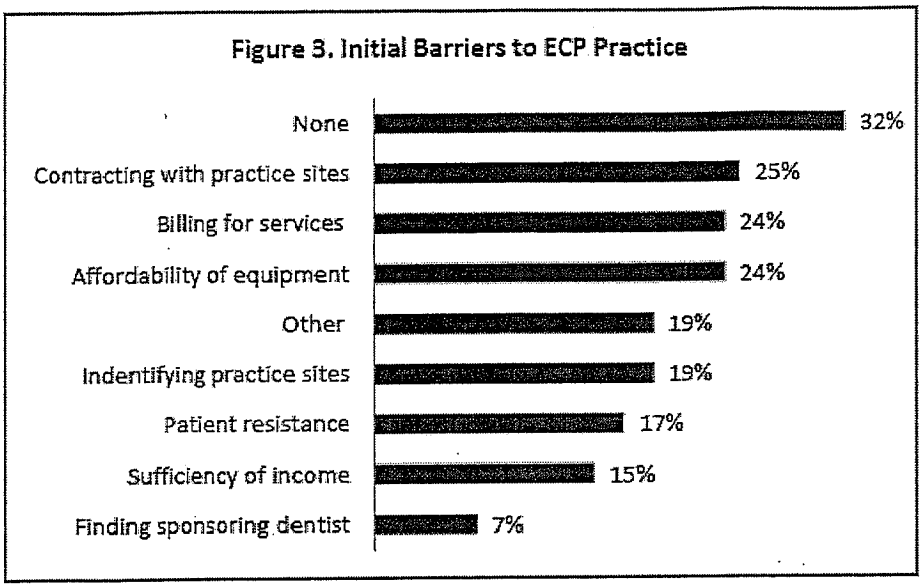
Attachment: # 10



ECP Policy Work Group

This fall Oral Health Kansas is partnering with the KDHE Bureau of Oral Health to facilitate a work group examining potential barriers in the ECP law to ECP hygienists' ability to practice. The work group is not yet done with its work, but it plans to formulate policy recommendations by the end of the year. The key barriers to ECP practice the work group is studying involve finance and access to the populations they serve:

Financial Barriers

- It is not currently feasible for ECP hygienists to make a living doing only ECP work.
- Running an effective ECP program involves a lot of non-billable time for outreach and paperwork.
- There is no Medicaid coverage of preventive services for adults: When the hygienists' services can be paid, the services are sustainable.

Access Barriers

- Some schools are hesitant to provide ECP hygienists access to the free and reduced price school lunch list.
- If an ECP hygienist is able to operate on her own, she needs to find a dentist or dentists who are willing to do the restorative work she finds people need.

While it is premature to speculate on the recommendations the ECP policy work group will make to Oral Health Kansas and the Bureau of Oral Health, it is reasonable to presume there will be a recommendation for the law to be revised to make it easier for ECP hygienists to see the students who qualify for ECP services. The work group is looking at many ways of accomplishing this goal, one of which may be to allow ECP hygienists to see any child without insurance.

Many options exist to make ECP work more financially viable, and we will explore these ideas with the Legislature as they are fine tuned. It is safe to say one of the options we will urge the Legislature to take action on is creating a comprehensive adult dental benefit in the Kansas Medicaid program.

Through the Affordable Care Act and the State Children Health Insurance Program Reauthorization Act, all children in the U.S. will be guaranteed access to a payment source for dental services. There is no such guarantee for adults. As such, when ECP hygienists find decay in the mouths of low-income adults they are working with, there is not a way to refer them to a dentist for restorative services.

I believe the Committee is approaching oral health in the right way by studying the state's ECP law. The premise of the law is that if more people are able to access preventive dental hygiene services, they will experience better oral health. This is the first step toward managing dental caries as a disease. Dr. Joel Berg, Chair of the Department of Pediatric Dentistry at the University of Washington and Director of Dentistry at Seattle Children's Hospital, noted this at a national conference two weeks ago. He said, "We can't drill and fill our way out of the problem." For thousands of years, we have treated the result of dental caries, not the cause. Focusing on getting dental hygiene services to people who have no other way to access them is an important step toward preventing oral disease and dental caries in the first place.

Thank you for your time. I am happy to stand for any questions.

KANSAS BOARD OF REGENTS

JOINT COMMITTEE ON HOME & COMMUNITY BASED SERVICES OVERSIGHT

November 8, 2010

Dr. Andy Tompkins
President & CEO

Chairman Bethell, Vice Chair McGinn, and members of the Committee, thank you for the opportunity to appear before you this morning on the important issue of dental service in Kansas.

The issue of dental service in Kansas is certainly not a new one. Kansas has taken several actions to compensate for the fact that it lacks a dental school, perhaps the most significant being the development of a reciprocity agreement that allows Kansans to study dentistry at the University of Missouri-Kansas City (UMKC) dental school at in-state tuition rates. Several allied health programs in the field of dentistry have also been developed at different institutions to provide support personnel for the dental profession.

In addition, the Kansas Department of Health and Environment (KDHE) administers the Kansas Dental Recruitment Program. This program provides recruitment assistance that includes outreach, a dental job clearinghouse, and a Dental Workforce Cabinet that directs the efforts of the recruitment program.

Kansas-Missouri Reciprocity Agreement

In 1964, Kansas and Missouri established a reciprocal tuition agreement that includes dentistry, optometry and architecture. Students receive an out-of-state tuition waiver that allows them to pay in-state tuition. The current agreement reserves 85 slots for Kansans in the University of Missouri-Kansas City dentistry programs. This agreement expires June 30, 2011 and we have begun the process of re-negotiating it.

Kansas residents may enroll in two different dental programs at UMKC: 1) they may enter the DDS program for students wanting a degree so they can become dentists; or 2) they may pursue a graduate certificate program after having earned their DDS degree. Typically three to four Kansas students enroll in one of six graduate certificate programs and receive tuition waivers each semester. The six graduate certificate programs are: 1) Advanced Education in General Dentistry; 2) Endodontics; 3) Oral and Maxillofacial Radiology; 4) Oral and Maxillofacial Surgery; 5) Orthodontics and Dentofacial Orthopedics; and 6) Periodontics.

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★ 1000 SW Jackson, Suite 520, Topeka, KS 66612-1368 ★ Tel 785.296.3421 ★ Fax 785.2

Under the terms of the reciprocity agreement:

- The University of Missouri-Kansas City dental school reserves 85 slots for Kansas students.
- Out-of-state tuition is waived for those students.
- Twenty new students enter the program annually.

From the fall of 2006 to the present, all 85 slots have been filled each semester, and an average of 23 new applicants annually apply to receive the waiver. There is no service requirement that Kansas residents who receive waivers to study dentistry at UMKC work as dentists in Kansas following graduation.

Ad Hoc Task Force on Oral Health in Kansas

In 2004-2005, the Wichita State University (WSU) College of Health Professions convened an Ad Hoc Task Force on Oral Health in Kansas. That task force produced a white paper on the state's dental needs that included the following observations:

- 91 of 105 Kansas counties are designated as "health professions shortage areas" for dentistry by federal government's Health Resources and Services Administration.
- From 1990-2002, an average of 15 UMKC dental graduates each year chose to practice in Kansas. Most who did so chose to work in the greater Kansas City metropolitan area
- The report stressed that Kansas needs to do two things: 1) increase the number of dental graduates choosing to practice in Kansas; and 2) increase the number of dental graduates choosing to practice in under-served areas of the state.

The white paper did not include a recommendation to establish a dental school in Kansas, focusing instead on strategies to increase the number of dentists practicing in Kansas, in particular in under-served areas, and on the feasibility of introducing educational options like the Advanced Education in General Dentistry (AEGD) that has been implemented at WSU.

Dental Programs in Kansas

Kansas currently has five programs training dental assistants and five educating dental hygienists. We also have one graduate certificate program, located at WSU.

Dental Assistant

Five Kansas schools currently offer dental assistant programs: Flint Hills Technical College in Emporia, Salina Area Technical College, Wichita Area Technical College, Advanced Dental Assisting School in Olathe, and Dental Careers of Kansas City.

Dental assistants in Kansas are not required to be licensed or have formal training to practice. Most dental assistants are trained on the job, though certificate programs do exist for those who desire postsecondary training. From 2005 through 2009, 276 students completed the dental assistant certificate program at the five institutions.

Dental Hygienist

There are five dental hygienist programs in Kansas. Colby Community College, Johnson County Community College, Flint Hills Technical College, and Manhattan Area Technical College offer associate degrees in dental hygiene. WSU offers an undergraduate degree in dental hygiene.

To practice in Kansas, dental hygienists must have graduated from an approved dental hygienist degree program and be licensed by the Kansas Dental Board. From 2005 through 2009, 358 students completed a dental hygienist degree at the six institutions.

Graduate Certificate

WSU offers the Advanced Education Program in General Dentistry (AEGD), and in the fall of 2009 WSU admitted its first class (seven students) to the program. The program is similar to a medical residency and is a one-year postdoctoral education program which offers dentists an opportunity for advanced comprehensive clinical experience in a variety of clinical settings.

Institutional Responses

I have consulted with the University of Kansas (KU) and WSU on the question of establishing a dental school in the state.

KU administrators note that establishing a dental school would be very costly. They estimate start-up costs of between $15 million and $87 million, depending on the scope of the project.

WSU supports a full public policy debate on the need for a dental school in Kansas. It further takes the position that if there is to be a dental school in Kansas, the logical place to locate the school would be at WSU because:

- WSU currently has the only accredited graduate dental program in the state (AEGD).
- A new building to house the AEGD program is under construction at WSU. This facility is supported fully by local donors interested in general education, indicating strong support for dental education in Wichita.
- Wichita is the largest city in Kansas and host to a wide variety of dental specialties in addition to general practice dentists.
- WSU has strong connections to rural Kansas through the WSU Regional Institute on Aging, which focuses on health issues related to Kansans aging in place.
- The WSU College of Health Professions includes a program in dental hygiene.
- The current Dean of the WSU College of Health Professions has experience in dental school administration. Thus, WSU has resident expertise in dental curricula and programs.
- The exact cost of starting a new dental school is unknown. However, WSU would collaborate to develop a full proposal for a school when such a proposal is appropriate.

Advantages of Establishing a Dental School

Possible advantages of establishing a dental school in Kansas include the ability to:

- Attract Kansas students who are more likely to remain in Kansas upon graduation;
- Develop programs that target rural dental care; and
- Maintain a student clinic that could provide services to individuals who might otherwise not receive them.

Disadvantages of Establishing a Dental School

Disadvantages of establishing a dental school in Kansas include the fact that such an action:

- Is a very expensive proposition—more expensive, in fact, than establishing a medical school according to experts at the KU Medical Center;
- Entails the added burden of recruiting and retaining faculty and administration; purchasing, maintaining and replacing equipment; and building and maintaining facilities; and
- Does not resolve the issue of retaining graduates both in Kansas and in under-served areas.

Other Options

Some other possible options, if we do not wish to pursue a dental school, are:

- *Enact a service requirement for Kansas residents attending UMKC dental programs and receiving out-of-state tuition waivers.*

  The estimated value of the waiver for the 4-year DDS degree is approximately $98,803 per student, based on current tuition rates.

  The estimated value of the waiver for the 4-year DDS degree for 85 students is approximately $8.4 million, based on current tuition rates.

- *Establish a scholarship program for dental students that pays the difference between in-state and out-of-state tuition at dental schools other than UMKC. These scholarships would come with a service requirement that might include additional incentives to work in under-served geographic areas.*

  Dental programs exist in other Midwest states (Nebraska, Iowa, Colorado, Oklahoma, Indiana, Ohio, etc.) and negotiations could be undertaken to secure seats for Kansas residents. Scholarships should not be awarded to Kansas residents attending UMKC since they can take advantage of the tuition waiver.

Mr. Chairman, thank you again for the invitation to appear before you today. I would be happy to answer any questions the Committee might have.

KAHSA

creating the future of aging services

To: Chairman Bob Bethell and Members,

Joint Committee on Home and Community-Based Services Oversight

From: Debra H. Zehr, President/CEO

Date: November 8, 2010

Promoting Oral Health for Older Kansans

Thank you for the opportunity to provide comments on expanding the role of dental hygienists in Kansas.

The Kansas Association of Homes and Services for the Aging (KAHSA) represents 160 not-for-profit aging service providers throughout the state. Their services include nursing home care, hospital long term care, assisted living and residential health care, housing, PACE, multi-level retirement communities, respite, adult day services and community-based services.

Good oral health is fundamental for optimum nutrition, communication, and social functioning of older Kansans who require long term care in the community or in facility-based settings. Promoting good oral and dental care is one of the most tenacious challenges facing long-term care staff and dental professionals. Some of the barriers include resident resistance due to dementia, long held poor oral health practices, lack of training at every level to deal with the special needs of the frail elderly, family disinterest, reimbursement for dental services, and staff turnover.

KAHSA has a long-standing commitment to promote policy and practices that support the best possible dental and oral care for the people our members serve. We helped champion initial legislation in the late 1990's to permit dental hygiene services without a dentist on the premises, in adult care homes, hospital long-term care units, indigent health clinics. Two years later we helped repeal the sunset to enable this important work to go forward. Other oral health-related activities KAHSA has engaged in over the years:

- The KAHSA Annual Quality First Award in Leading Edge Care and Services was given to members demonstrating excellence and innovation in oral health care in 2001, 2005 and again in 2008.
- Partnered with the American Academy of General Dentistry, Oral Health Kansas and the United Methodist Health Ministry Fund for two years in the mid-2000's to conduct "mini-residency" program to educate dental professionals about the long term care practice setting and special needs of the frail elderly.

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- Partnered with the United Methodist Health Ministry Fund to provide trainings around the state for hands-on caregivers in long term care on oral health care.
- Worked with state agency personnel to provide live trainings, articles and brochures on the Medicaid PETI provision.
- Offer free Lending Library resources to help our members provide in-house oral health and oral care training.
- Co-sponsored joint training last year for providers and long term care surveyors on oral health.
- Provided concurrent education sessions for nurses on oral assessment, medication and disease impact on oral and dental health and related topics.
- Routinely share oral care promotion resources and best practices through our electronic newsletter, quarterly magazine and on our website.
- Co-founded Promoting Oral Health for Elder Kansans, a coalition of representatives from provider and consumer organizations, and state agencies operating from 1997 to the mid-2000's to promote oral healthcare for senior Kansans residing in long-term care settings.
- Co-founded Kansas Elder Smile, a statewide award program operating in the early 2000's that recognized and publicized best practices in oral care in long-term care settings.

KAHSA strongly support permitting dental hygienists to provide training and services in adult care homes, hospital long-term care units, indigent health clinics and other settings. We commend the Joint Committee on HCBS Oversight for exploring ways to promote good oral health for the citizens of our state.

For questions of further information please feel free to contact me at dzehr@kahsa.org.

Thank you.

Samples/Excerpts from publications on KAHSA Oral Health-Related Activities

Western Prairie Smiles Program Goes "Mobile"

Late in 2006, Western Prairie Care Home in Ulysses, KS recieved a $45,000 grant from United Methodist Health Ministries Fund. This grant will allow them to help set up a mobile preventative oral health clinic to address the concerns of poor oral health with periodic visits to area nursing homes. At least nine other long-term care organizations expressed an immediate interest in the services, which provided a pool of 574 potential clients in southwest Kansas counties. Therefore, the Western Prairie Smiles Program was created.

Angela Black and Mary Ellen Caldwell

Angela Black and Mary Ellen Caldwell, registered dental hygienists (RDHs), jumped in to get the program started by getting an extended care permit, so they could begin providing dental services. Then they selected, shopped for, and ordered the needed equipment. A used, lift-equipped van was purchased to haul the equipment, and they were off to help long-term care residents in early 2007.

When the RDHs arrive, they use an empty room such as a resident's room or beauty shop, and they can quickly set up their clinic. The program provides oral screenings, digital x-rays, cleaning, fluoride varnish treatments, denture cleaning, oral hygiene instructions for staff, patients and family members, simple partial and denture adjustments as well as dentist referrals.

"We stress that the [Smiles Program] does not replace a visit to the dentist," said Billie Upshaw, administrator of Western Prairie Care Home. "We provide the care and service provided during a routine dental appointment, up until the dentist walks into the room. The services are provided to the resident in familiar surroundings with familiar care home staff, and the opportunity for a positive outcome to the visit is increased."

Mary Ellen makes this elder's smile a little brighter!

Along with improving the oral health of long-term care residents, Angela also hopes to educate the nursing staff and family members about how poor oral health impacts the whole body and person. "By improving the oral health of our elders, they should not be in pain, eat better, maintain body weight, and feel better overall," said Angela. "A healthy smile improves self-esteem and confidence, too.

Chris Sneath of Lone Tree Care Home in Meade, KS has partnered with Western Prairie Smiles as it meets dental needs in rural Southwest Kansas. Not only is Lone Tree excited about the program for the residents, but the staff has decided to use digital images in conjunction with in-services to educate others about the importance of oral care in the resident's overall health. Angela's plan of educating staff and family members is becoming active because of the staff at Lone Tree.

As for what the program was like for Lone Tree residents, Chris could not say enough good things. "We have had the hygienists here in our building one time, and what a pleasure it was," exclaimed Chris. "[The hygienists] were all smiles, gentle, kind, and considerate to our residents. They made the residents feel totally at ease, even those who are not comfortable in a medical setting. We believe receiving these services in our home contributed to acceptance for everyone, including family members."

The Western Prairie Smiles Program began providing services at the beginning of 2007, but Angela hopes to cover SW Kansas care homes, assisted living centers, and senior center settings as the program continues to grow.

12-4

A Dentist's Passion for Seniors

It can be difficult to work with people who are not sure where they are, or what is happening around them. Add a menacing chair, bright lights and strange mechanical devices, and you have the daunting task of performing dental work on those suffering with dementia. Few dentists work well in such an environment and fewer yet would say that they enjoy it, but one such dentist is Ruth Anne Seabaugh.

"When you have people with dementia and Alzheimer's, and they aren't sure what is going on – that is Ruth Anne's gift," says Karen Agron Flattery, Chief Development Officer of the Village Shalom Charitable Supporting Foundation.

Ruth Anne is a geriatric expert, and has been working with those suffering from dementia for 20 years. "I started in a regular Johnson County dental office, but quickly discovered a gift for working with the older population – especially those with dementia. Communication with their family is huge, spending enough time talking with them about their loved one's needs and the care they will receive."

Karen Agron Flattery, Dr. Ruth Anne Seabaugh and Matt hew Lewis.

It all started about 18 months ago when Ruth Anne was talking with a friend about the need for this kind of specialized services. This conversation led to Dr. Seabaugh and her friend meeting with Ms. Flattery and Matthew E. Lewis, president and CEO of Village Shalom, about an onsite dental facility, and the funding needs for those on financial assistance.

Dr. Seabaugh's friend graciously and anonymously donated the money to establish the on-site dental clinic for residents. "Many residents could not access dental care," stated Ms. Flattery. "The average dental office is not set up for those with physical difficulties, to sit and comfortably receive dental care."

Village Shalom now has a dedicated facility with state of the art equipment. "The new dental clinic makes it possible for all of our residents to receive regular dental care regardless of their physical or emotional limitations," says Lewis. "Dr. Seabaugh has already been extremely well received by our residents and families and we are fortunate to have her on-site two days a week."

"It is wonderful to have this facility, and to be able to serve without worrying about the financial side – especially for residents and their families," adds Dr. Seabaugh. She also appreciates the efforts of the entire staff. "If we give someone a denture and they lose it, that can be a big problem. The staff has been great about working with the residents, and making sure things like that don't happen. We have a wonderful and caring staff which is incredibly important, and the backing of committed and involved families."

"I love this community, and I will continue to work here as long as I can," exclaims Dr. Seabaugh. "I will live here and still be working here!"

Are you interested in receiving a subscription to the FOCUS? Contact Dana Weaver at dweaver@kahsa.org or 1-800-264-5242 for more information.

12-5

2008

AWARD WINNERS CONTINUED

view process together, a CareFronting conflict-resolution program, career ladders, and the development of strength-based leadership teams in their neighborhoods and households.

Pleasant View Home is providing person-centered care to the residents as well as their staff. They believe that the special dedication to their employees not only sends staff satisfaction soaring, but elders receive the special attention and consistent care they need.

Leading Edge Care and Services
Lone Tree's Dental Project:
Lone Tree Retirement Center in Meade

Debra Zehr, Pam Bachman, Chris Sneath, and Connie Hubbell

Oral care is often overlooked by older people. Proper oral health care can vastly improve the quality of life for individuals with dental problems, which is why it has been a focus at Lone Tree Retirement Center since 2007.

Western Prairie Smiles, a mobile dental unit designed to work with nursing home residents, comes to the Center on a regular basis. They provide in-house basic dental exams, cleanings, and referrals to dentists for the residents. The Center has documented better appetites, lower infection rates, a reduction in pain complaints and an overall feeling of well-being for those who have received the service.

Proper dental care is not cheap, and many of the individuals needing the service could not afford to pay for regular visits, so the staff held several fund-raisers to pay for the care. The fundraisers have been so successful, there is no charge to any of the Lone Tree residents who receive care from the Western Prairie Smiles Program.

All staff have taken a role in providing this service to their residents and will continue to do so in the years to come.

Consumer-Friendly Information
Viewpoint: Local Voices of WW II:
Larksfield Place in Wichita

WWII Veterans from Larksfield Place

Larksfield Place has a history of serving the greater Wichita community in a way that honors the "Greatest Generation". Their I Witness to History Program captures the stories of this generation and preserves them for future generations to enjoy. The Viewpoint: Local Voices of WWII was a program that focused on the Veterans of this war and showcased them on the local PBS station.

Nine individuals from Larksfield Place and the community were featured in the 90 minute, two-part documentary that aired on KTPS - Channel 8 last fall. The documentary ran in conjunction with a Ken Burns feature of World War II titled The War. Larksfield Place hosted nearly 300 World War II veterans and their family members at several premieres held prior to the airing.

As a result of the project, two of the gentleman interviewed have started to write their stories and nine books are planned based upon the transcripts of the full interviews.

Education Overview - Two More Successes!

KAHSA's Twentieth Annual Social Service, Activity Director and Chaplaincy Conference - a resounding success according to participants, speakers and KAHSA staff. Held March 9 and 10 at the Wichita Airport Hilton, this year's meeting attracted over 125 participants.

Said Kevin McFarland, LBSW, Executive Vice President, KAHSA: "Erin Doucette Bonitto is a must-see presenter. Her expertise and real life practical approaches in the memory care setting were right on target. Tom Welk's insightful and provocative discussion regarding current day ethical issues provided a foundation for the attendee's health ethics committee in their organization."

Erin Doucette Bonitto, MS, ADC, Gemini Consulting, presented two sessions that focused on activities and interventions for residents with dementia.

Participants of these sessions had this to say: "I really liked the effective activity definition and the explanation of the highest level of response."

Tom Welk, DMin, Harry Hynes Hospice, was also back this year to present an intensive session on Medical Ethics for the social worker. As always, his professional and compassionate presentation of this material met with great success.

Said participants: "Medical Ethics - always a challenging topic - very well discussed."

Tina Ashford, CTRS presented a comprehensive session on the Revised Interpretive Guidelines for F-Tags 248 and 249 - Activities Programs. The session focused on the proposed guidelines and changes for activities and how documentation and programming techniques will be affected in supporting resident centered care.

A special luncheon, moderated by Tom Welk, gave chaplains and clergy an opportunity to discuss the challenges and triumphs they face as they provide spiritual care to residents of long term care organizations.

On March 22 - 25th, KAHSA and Oral Health Kansas, along with sponsorship from United Health Ministries, presented a Dental Mini-Residency.

This intensive three day workshop gave oral health providers an opportunity to learn about oral health care in long-term care and how the Kansas Extended Care Permit supports increased access to dental hygiene services for residents of long term care organizations.

The presenters of this workshop were Stephen Shuman, DDS, MS, Peggy J. Simonson, RDH, BS, Maggie Smet, RDH, and Marcia Manter, M.A.

Two dentists and 21 hygienists participated in this event. Loretta Seidl, RDH, MHS, Director of Professional Development, KAHSA said: "The energy and excitement from the group and their obvious enthusiasm to improve oral hygiene care for our residents has been astounding. It gives me pleasure to see such great dedication from my colleagues."

KAHSA Educational Calendar

June 5 & 6	Designs for Aging Conference	Overland Park
June 7	Regional Survey Update	Parsons and Salina
June 14	"I Care" Plans	Webinar
June 16	When the Nursing Home is Home: How Can Hospice Help?	Wichita
June 20	CNA Center for Excellence: Care Planning Process	Hays
June 21	Regional Survey Update	Hays and Wichita
June 21	CNA Center for Excellence: Care Planning Process	Garden City
July 14	Liability Issues	Webinar
July 19	Fire Marshall Update	Topeka
July 20	Fire Marshall Update	Wichita
July 26	Medicaid	Webinar

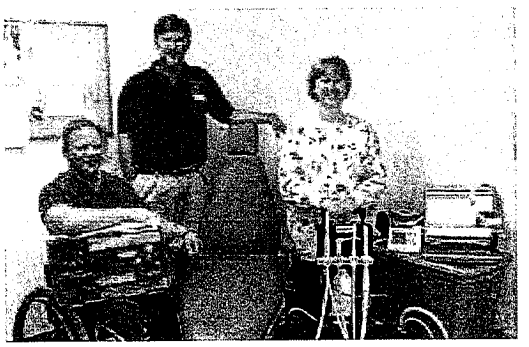
*Visit our website for more educational opportunities at www.kahsa.org .

12-7

Salute To The 2005 Quality First Award Winners!

The members of the Kansas Association of Homes and Services for the Aging have a long and rich tradition of not-for-profit, mission-driven caring for elders in their local communities. They are committed to continuing this journey in the 21st century, striving to provide the best care and services possible, based on the deep-rooted ideals of quality, choice, community and value.

Three years ago, the American Association of Homes and Services for the Aging stepped forward to launch Quality First, a comprehensive initiative to achieve excellence in aging services and establish public trust. Quality First encompasses all types of aging services, including housing, assisted living, nursing home care, hospital-based long-term care and community-based services. It emphasizes quality in seven areas: continuous quality improvement; public disclosure and accountability; consumer and family rights; workforce excellence; community involvement; ethical practices; and financial integrity. By embracing Quality First principles, KAHSA members have pledged to work in partnership with consumers and government to create an environment in which our elders can feel confident that they are receiving the high quality care and service they deserve.



Leading Edge Care & Services Award - Wheat State Manor

The Leading Edge Care and Services Award recognizes a KAHSA member that has implemented models and practices successfully representing the tradition of personal service, with exceptional practices in meeting community needs, innovative uses of technology, CQI and unique care and services.

Although oral health is something many people take for granted, research findings have pointed to possible associations between chronic oral infections, diabetes, heart and lung diseases and stroke. Understanding the importance of oral care, Wheat State Manor of Whitewater launched its innovative "We SMile" Mobile Preventive Oral Health Clinic with a $43,000 grant from the United Methodist Health Ministry Fund. The traveling clinic currently provides services to elders living in five long-term care communities in Whitewater, Newton, Hesston and Moundridge.

Wheat State Manor has done a remarkable job of bringing partners together to understand and fill an unmet need of the local citizenry. The "We SMile" initiative is improving the quality of life for many older persons.

Community Involvement Award - Anthony Community Care Center

The Community Involvement Award recognizes an association member who has demonstrated social accountability, diversity outreach and relationship building through consumer outreach and education and community relations activities.

When the out-of-state owners of Anthony Community Care Center decided to close it, the entire town rallied to save their nursing home. The city purchased the home and community groups came together to provide much-needed building renovations and new equipment. Improvements over the years have included a therapeutic garden, repainting and remodeling, adding furniture, paving the road and parking areas.

Without the constraints of corporate ownership, the management team at Anthony Community Care Center began a journey to provide resident centered care for the elders living at the home.

The people of Anthony have done an outstanding job of pulling together to care for their elders, and their experience serves as a role model for other small rural communities.

12-8

2005 An Exciting Year For KAHSA/ARI Educational Opportunities

2005 was an exciting year for education. Aging Research Institute brought KAHSA members and other long-term care providers many opportunities to learn, network and expand the boundaries of what it means to provide the best possible care and choices for the elders we serve.

From keeping updated on current legislative and legal issues at the HIPAA workshops and Public Policy Conference, to MDS Compliance and reimbursement issues covered in our RAI workshops, to education events focused on the latest models of care that challenge the way we think about aging, ARI's 2005 education programs were developed with KAHSA's core values in mind: Community, Quality, Value and Choice.

KAHSA members had the opportunity to learn, network and expand their boundaries at ARI educational offerings in 2005.

Highlights include:

Seventeen innovative and exciting trainings were brought to hundreds of front line staff, with ten scholarships awarded. Topics included falls, pressure ulcers, restorative nursing and oral health.

LaVrene Norton of Action Pact delivered a passionate, knowledgeable keynote presentation at the Spring Convention about the need for change and choices in the ways we care for our elders. The impact of her presentation was noted by participants as reflected in comments like these: "LaVrene's knowledge and passion are inspiring." "LaVrene brings activities of involvement and the art of storytelling to life." And "Every time LaVrene speaks, new information is gleaned that is a lightbulb going off. Great!"

Joint Trainings with Adult Care Providers and KDOA Surveyors: CMS New Surveyor Guidance on Pressure Ulcers: What You Need to Know and Do. These workshops had record attendance by both long term care providers and KDOA surveyors. So many people wanted to attend this valuable seminar, a third was scheduled to accommodate all who needed this information. Participants all agreed that presenter Diane Atchinson was knowledgeable, dynamic and easy to understand.

Team Trainings on The Montessori Approach to Persons with Dementia and Spaced Retrieval were held this year. Dr. Cameron Camp and his associate, Megan Malone, presented these cutting-edge techniques in memory retrieval and retention and showed how astoundingly effective and easy to learn they were.

Recently, at The Montessori Approach to Persons with Dementia at Manor of the Plains in Dodge City, Carol Tedford, of Minneola District Hospital Long Term Care, had this to say "I just wanted to tell you what a wonderful response we are having in our facility to the Montessori "train the trainer" session in Dodge City. Our activity aide who attended came back so fired up and enthused! In two days she has generated more interest in resident empowerment than the management team has been able to create in two years. Suddenly, ideas are flowing like a river from both staff and residents, and being met with enthusiasm and energy. The impact is quite different when the message comes from someone other than the DON or myself--suddenly it's not just one more concept we're trying to sell them on. Thank you for offering such a quality program out in our area and for encouraging us to involve more staff members in educational opportunities."

These are just a few of the memorable highlights of education events this year.

As always, KAHSA and ARI strive to bring long-term care providers innovative, cutting edge educational programming. With tools such as member surveys, feedback at individual events, participation by members in education planning meetings, and networking with professionals in the field of adult learning, KAHSA and ARI strive to meet our members' education needs in better and different ways, including learning opportunities in settings that are new and different, including webinars and regional education events that bring learning closer to home. Contacts for education at KAHSA are: Loretta Seidl, Director of Professional Development, Denise Howell, Education Program and Marketing Coordinator, and Melissa Sica, Education and Associate Member Specialist. Your ideas and comments are always welcome and appreciated.

KAMU
THE PRIMARY CARE ASSOCIATION OF KANSAS

strength
unity
advocacy

Testimony on:

Dental Access/Workforce

Presented to:

Home and Community Based Services Oversight Committee

By:

Connie Hubbell, Director of Governmental Affairs
Kansas Association for the Medically Underserved

November 8, 2010

For additional information contact:

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Home and Community Based
Services Oversight
Date: 11-8-10
Attachment: #13

Mr. Chairman and members of the Home and Community Based Services Oversight Committee, I am Connie Hubbell providing written testimony on behalf of the Kansas Association for the Medically Underserved (KAMU).

To respond to a question raised at your last committee meeting, regarding how the number of Kansas dentists who serve Medicaid patients compares to the National average - data shows that 25% of Kansas dentists see Medicaid patients, and nationally, 33% of America's dentists see Medicaid patients.

The second issue that the committee requested an update on is information regarding the waiting list and the wait time for patients to receive dental care in the primary care safety net clinics in Kansas. Each clinic manages their scheduling system to meet their needs. Many clinics do not have a wait list and or a very long wait time, while others do have waiting lists as well as fairly long wait times for appointments. In large part, this is due to their policy on scheduling. Some only accept appointments up to a month in advance since many patients' situations change making it difficult to keep an appointment scheduled far in advance. Others leave some of their schedule open to allow for emergency, same-day appointments and/or walk-ins. With such a variance in policies, it is difficult to report an average among the clinics in these categories. The following information will hopefully help inform the committee's discussion.

- There are 17 safety net dental clinics in Kansas. A concern of KAMU and these 17 clinics is the increased demand for dental care and the need for additional resources to meet this increased demand. It is definitely a workforce issue as well as an access issue. Due to workforce and access issues, - at least one reporting clinic turns away an average of 20 patients a week while another turns away an average of 40+ patients a week.
- Waiting lists don't necessarily equate to access challenges because of the varied scheduling approaches used by the clinics. The 17 Kansas safety net dental clinics saw 54,116 patients in 2009 out of approximately 910,000 uninsured/underinsured Kansans.

Facts regarding waiting list and wait time:

- Over half of the reporting clinics have a wait list
- Wait time ranges from same or next day to 4 months
- The number of patients on the wait list ranges from 3 patients to 292 patients
- Two reporting clinics keep two wait lists – one for patients requesting to see the hygienists and another wait list for those needing to see a dentist. Both clinics have a longer wait time for patients needing to see the hygienist

KANSAS ASSOCIATION FOR THE MEDICALLY UNDERSERVED
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Adult Protective Service Substantiations and Rates
Comparison of Pre- and Post-Policy by Age

		Under 65				*Over 65*			
Cal Yr	Month	Total Investigations	Unsubstantiated	Substantiated	Substantiated Rate	Total Investigations	Unsubstantiated	Substantiated	Substantiated Rate
2009	Oct	435	370	65	14.9%	331	284	47	14.2%
	Nov	366	295	71	19.4%	292	253	39	13.4%
	Dec	317	255	62	19.6%	361	313	48	13.3%
	Average	373	307	66	17.7%	328	283	45	13.6%
2010	Jan	433	366	67	15.5%	317	276	41	12.9%
	Feb	356	288	68	19.1%	330	283	47	14.2%
	Average	395	327	68	17.1%	324	280	44	13.6%

Home and Community Based
Services Oversight
Date: 11-8-10
Attachment: #14

PARENT FEE PROGRAM
Number of Families by Fee Level and Waiver
As 0f November 3, 2010

Monthly Fee*	Waiver Program						TOTAL
	Autism	Developmental Disabilities	Physical Disabilities	Traumatic Brain Injury	Technologically Assisted	Serious Emotional Disturbance	
Total Eligibles	**44**	**2,934**	**0**	**7**	**394**	**3,440**	**6,819**
$10	1	18			8	48	75
$15	2	24			5	44	75
$20	1	19			5	46	71
$26		10			4	29	43
$33	1	18			2	15	36
$41	3	9			1	19	32
$49		9			3	9	21
$58	1	12			2	5	20
$68	1	6				2	9
$79	1	2			3	9	15
$90		4			2	5	11
$102		8			1	6	15
$115		4			1	1	6
$129	1	4			1	7	13
$143		2			3	1	6
$159	1				2		3
$174							-
Over $174	3	7			4	8	22
Total Eligibles with Fees	16	156	0	0	47	254	473
Total Eligibles without Fees	28	2,778	0	7	347	3,186	6,346

Parent Fee Schedule

(Sometimes referred to as "Sliding Fee Scale")

Effective February 1, 2010

Federal Poverty Level (FPL)	Monthly Fee	A		B		C		D	
		Family of Two *		Family of Three *		Family of Four *		Family of Five or More *	
		Adjusted Gross Income		Adjusted Gross Income		Adjusted Gross Income		Adjusted Gross Income	
		Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly
100%	$0	$14,570	$1,214	$18,310	$1,526	$22,050	$1,838	$25,790	$2,149
151%	$0	$22,001	$1,833	$27,648	$2,304	$33,296	$2,775	$38,943	$3,245
176%	$0	$25,643	$2,137	$32,226	$2,686	$38,808	$3,234	$45,390	$3,783
201%	$10	$29,286	$2,441	$36,803	$3,067	$44,321	$3,693	$51,838	$4,320
226%	$15	$32,928	$2,744	$41,381	$3,448	$49,833	$4,153	$58,285	$4,857
251%	$20	$36,571	$3,048	$45,958	$3,830	$55,346	$4,612	$64,733	$5,394
276%	$26	$40,213	$3,351	$50,536	$4,211	$60,858	$5,072	$71,180	$5,932
301%	$33	$43,856	$3,655	$55,113	$4,593	$66,371	$5,531	$77,628	$6,469
326%	$41	$47,498	$3,958	$59,691	$4,974	$71,883	$5,990	$84,075	$7,006
351%	$49	$51,141	$4,262	$64,268	$5,356	$77,396	$6,450	$90,523	$7,544
376%	$58	$54,783	$4,565	$68,846	$5,737	$82,908	$6,909	$96,970	$8,081
401%	$68	$58,426	$4,869	$73,423	$6,119	$88,421	$7,368	$103,418	$8,618
426%	$79	$62,068	$5,172	$78,001	$6,500	$93,933	$7,828	$109,865	$9,155
451%	$90	$65,711	$5,476	$82,578	$6,882	$99,446	$8,287	$116,313	$9,693
476%	$102	$69,353	$5,779	$87,156	$7,263	$104,958	$8,747	$122,760	$10,230
501%	$115	$72,996	$6,083	$91,733	$7,644	$110,471	$9,206	$129,208	$10,767
526%	$129	$76,638	$6,387	$96,311	$8,026	$115,983	$9,665	$135,655	$11,305
551%	$143	$80,281	$6,690	$100,888	$8,407	$121,496	$10,125	$142,103	$11,842
576%	$159	$83,923	$6,994	$105,466	$8,789	$127,008	$10,584	$148,550	$12,379
601%	$174	$87,566	$7,297	$110,043	$9,170	$132,521	$11,043	$154,998	$12,917

* Number of exemptions claimed on your Federal Income Tax Return

AGI - Adjusted Gross Income per your Federal Income Tax Return

For Incomes Below 601% of the Federal Poverty Level

1 Find the column for your family size
2 Find the lines that your AGI fall between
3 Find the corresponding estimated "Monthly Parent Fee" for the smaller of the 2 AGIs in Step 2.

EXAMPLE

1 For a family of two (Col A), with an AGI of $36,000
2 The AGI falls between $32,928 and $36,571.
3 The Monthly Parent Fee of $15 that corresponds to the smaller AGI of $32,928 is the estimated fee.

For Incomes Above 601% of the Federal Povery Level

1 Fee is 3% of the income of a family size of 2 at the corresponding FPL

EXAMPLE

1 For a family of four (Col C) with an AGI of $225,000
2 Divide $225,000 by $22,050 = 1021% of FPL
3 Multiply 1021% by $14,570 (AGI for Family of 2-Col A) = $148,760
4 Multiply $148,760 by 3% = $4,462
5 Divide $4,462 by 12 Months = $371.84 (Monthly Fee)

Updated January 2010 - based on Federal Register 2009 Poverty Guidelines for 48 Contiguous States

PARENT FEE PROGRAM
COLLECTION INFO
As of November 3, 2010

Waiver Program	# of Accounts	Total Outstanding & eligible for SDSO *
Autism	6	5,052.00
Developmental Disability	53	176,988.39
Physical Disability	0	
Traumatic Brain Injury	0	
Technologically-Assisted	13	31,200.00
Serious Emotional Disturbance	158	132,115.25
TOTAL	171	345,355.64

* SDSO = State Debt Set Off

Reports generated by the Parent Fee Program software are cumulative from the beginning of the Parent Fee Program.

Collections through SDSO

SFY	DD	SED	TA	TOTAL
2010	10,643.00	2,552.00	284.00	13,479.00
2009	2,403.00	5,318.00	1,210.00	8,931.00
2008	9,462.00	5,914.00	1,318.00	16,694.00
2007	4,101.00	1,559.00		5,660.00
2006	8,688.00	2,573.00	317.00	11,578.00
2005	19,599.00		1,739.00	21,338.00
TOTAL	54,896.00	17,916.00	4,868.00	77,680.00

HOME AND COMMUNITY BASED SERVICES OVERSIGHT COMMITTEE

ANNUAL REPORT FOR THE 2011 LEGISLATIVE SESSION

The Home and Community Based Services Oversight Committee is charged by statute to submit an annual written report on the statewide system for long-term care services to the President of the Senate and the Speaker of the House of Representatives at the start of each regular legislative session. The authorizing legislation (KSA 39-7,159) creating a comprehensive and coordinated statewide system for long-term care services became effective July 1, 2008.

The Committee's Annual Report is to be based on information submitted quarterly to the Committee by the Secretary of Social and Rehabilitation Services and the Secretary of Aging. The Annual Report is to provide:

- The number of individuals transferred from state or private institutions to home and community based services including the average daily census in state institutions and long-term care facilities;
- The savings resulting from the transfer of individuals to home and community based services as certified by the Secretary of Social and Rehabilitation Services and the Secretary of Aging; and
- The current balance in the Home and Community Based Services Savings Fund.

Number of individuals transferred from state or private institutions to home and community based services including the average daily census in state institutions and long-term care facilities:

Number of Individuals Transferred – the following chart provides a summary of the number of individuals transferred from developmental disability institutional settings into home and community based services during state fiscal year 2010, together with the number of individuals added to home and community based services due to crisis or other eligible program movement during state fiscal year 2010.

DD. INSTITUTIONAL SETTINGS	
Private ICFs/MR ~ number served at start of SFY 2010	178
State DD Hospitals – SMRH ~ number served at start of SFY 2010	358
MFP (# persons discharged into MFP program) **Private ICFs/MR**	-7
MFP (# persons discharged into MFP program) **Public ICFs/MR SMRH**	-14
(# persons discharged NOT into MFP) **Private ICFs/MR**	-6
(# persons discharged NOT into MFP) **Public ICFs/MR SMRH**	-12
Sub-Total - **Private ICFs/MR**	165
Sub-Total - **Public ICFs/MR -SMRH**	332
New Admissions **Private ICFs/MR**	7
New Admissions **Public ICFs/MR**	18

Sub-Total - **Private ICFs/MR**	172
Sub-Total - **Public ICFs/MR -SMRH**	350
Net TOTAL Changes **Private ICFs/MR**	-6
Net TOTAL Changes **Public ICFs/MR**	-8
TOTAL DD Institutional Changes	-14
DD HCBS WAIVER SERVICES	
DD Waiver Community Services ~ number served at start of SFY 2010	7596
MFP ~ number joining into this program throughout SFY 2010	21
Subtotal	7617
Net number of persons added to DD HCBS waiver community services due to crisis/other eligible programs	173
Subtotal	7790
Total Net Changes DD Waiver	194
Total Net Changes DD Waiver and Institutional	180

The following chart provides a summary of the number of individuals transferred from nursing facility institutional settings into home and community based services during state fiscal year 2010, as well as other eligible institutional service growth during state fiscal year 2010; and reflects the grand total net changes across all related systems.

FE / PD / TBI INSTITUTIONAL SETTINGS	
Nursing Homes-Avg Mo Caseload SFY 09	10,817
MFP FE (# persons discharged into MFP program receiving FE Services)	-40
MFP PD (# persons discharged into MFP program receiving PD services)	-38
MFP TBI (# persons discharged into MFP program receiving TBI services)	-4
Additional people-Net Admissions/Discharges	-293
Nursing Homes-Avg Mo Caseload SFY 10	10,442
FE / PD / TBI COMMUNITY SERVICES	
FE WAIVER ~ number served at start of SFY 2010	5,706
PD WAIVER ~ number served at start of SFY 2010	7,400
TBI WAIVER ~ number served at start of SFY 2010	294
FE MFP ~ number joining into this program throughout SFY 2010	40
PD MFP ~ number joining into this program throughout SFY 2010	38
TBI MFP ~ number joining into this program throughout SFY 2010	4
SUBTOTAL FE	5,746
SUBTOTAL PD	7,438
SUBTOTAL TBI	298
Change due to OTHER reasons FE Waiver	67
Change due to OTHER reasons PD Waiver	-511
Change due to OTHER reasons TBI Waiver	79
SUBTOTAL FE	5,813
SUBTOTAL PD	6,927
SUBTOTAL TBI	377
Total Net Changes FE/PD/TBI Waivers	-283
Total Net Changes FE/PD/TBI Waivers and Institutional	-658
GRAND TOTAL NET CHANGES ALL SYSTEMS – DD/FE/PD/TBI HCBS and INSTITUTIONAL	**-478**

Average Daily Census -

Kansas Neurological Institute:	FY 2008 – 160 FY 2009 – 158 FY 2010 - 157
Parsons State Hospital:	FY 2008 – 194 FY 2009 – 192 FY 2010 - 186
Private ICFs/MR:	FY 2008 – 236 FY 2009 – 178 FY 2010 - 171
Nursing Facilities:	FY 2008 – 10,581 FY 2009 – 10,817 FY 2010 – 10,442

Savings resulting from the transfer of individuals to home and community based services.

The "savings" through Money Follows the Person translates into real dollars only when individuals move into a community setting from an institutional setting and the bed is closed behind the individual. This process would result in a decreased budget for private ICFs/MR and an increase in the MR/DD Waiver budget as a result of the transfers.

For nursing facilities and state ICFs/MR, the process is consistent in regards to individuals moving to the community. The difference is seen in regards to "savings". As stated above, savings are only seen if the bed is closed. In nursing facilities and state ICFs/MR the beds may be refilled when there is a request by an individual for admission that requires the level of care provided by that facility. Therefore the beds are not closed. Further, even when a bed is closed only incremental savings are realized in the facility until an entire unit or wing of a facility can be closed.

In addition to these considerations, the fact that people come onto the waivers for reasons other than transferring from an institution affects what possible savings there are in the respective systems. The savings realized are cost avoidance savings, in that individuals transferring from institutional to community services results in a smaller growth in institutional service utilization. This supports an increase in access to community based services, retains all resources within the service system, and results in proportionally slower growth of costs in the system.

As certified by the Secretary of Social and Rehabilitation Services and the Secretary on Aging, the savings resulting from the individuals to home and community based services as of November 1, 2010 was $0.

Current Balance in the SRS Home and Community Based Services Savings Fund and the KDOA Home and Community Based Services Savings Fund.

SRS Savings Fund - the balance in the SRS Savings Fund as of November 1, 2010 was $0.

KDOA Savings Fund - the balance in the KDOA Savings Fund as of November 1, 2010 was $0.

HOME AND COMMUNITY BASED SERVICES OVERSIGHT COMMITTEE

FIRST QUARTER FY2011

Number of Individuals Transferred – the following chart provides a summary of the number of individuals transferred from developmental disability institutional settings into home and community based services during the 1st quarter of state fiscal year 2011, together with the number of individuals added to home and community based services due to crisis or other eligible program movement during the 1st quarter of state fiscal year 2011.

DD INSTITUTIONAL SETTINGS	
Private ICFs/MR ~ number served at start of SFY 2011	172
State DD Hospitals – SMRH ~ number served at start of SFY 2011	350
MFP (# persons discharged into MFP program) **Private ICFs/MR (1st quarter)**	-1
MFP (# persons discharged into MFP program) **Public ICFs/MR SMRH (1st quarter)**	-4
(# persons discharged NOT into MFP) **Private ICFs/MR (1st quarter)**	-5
(# persons discharged NOT into MFP) **Public ICFs/MR SMRH (1st quarter)**	-4
Sub-Total - **Private ICFs/MR**	166
Sub-Total - **Public ICFs/MR -SMRH**	342
New Admissions **Private ICFs/MR (1st quarter)**	2
New Admissions **Public ICFs/MR (1st quarter)**	4
Sub-Total - **Private ICFs/MR**	168
Sub-Total - **Public ICFs/MR -SMRH**	346
Net TOTAL Changes **Private ICFs/MR**	-4
Net TOTAL Changes **Public ICFs/MR**	-4
TOTAL DD Institutional Changes	-8
DD HCBS WAIVER SERVICES	
DD Waiver Community Services ~ number served at start of SFY 2011	7794
MFP ~ number joining into this program throughout the 1st quarter of SFY 2011	5
Subtotal	7799
Net number of persons added to DD HCBS waiver community services due to crisis/other eligible programs	92
Subtotal	7891
Total Net Changes DD Waiver	97
Total Net Changes DD Waiver and Institutional	89

14-8

The following chart provides a summary of the number of individuals transferred from nursing facility institutional settings into home and community based services during the 1st quarter of state fiscal year 2011, as well as other eligible institutional service growth during the 1st quarter of state fiscal year 2011; and reflects the grand total net changes across all related systems.

FE / PD / TBI INSTITUTIONAL SETTINGS	
Nursing Homes-Avg Mo Caseload SFY 10	10,442
MFP FE (# persons discharged into MFP program receiving FE Services) (1st quarter)	-19
MFP PD (# persons discharged into MFP program receiving PD services) (1st quarter)	-37
MFP TBI (# persons discharged into MFP program receiving TBI services) (1st quarter)	-2
Additional people-Net Admissions/Discharges (1st quarter)	-423
Nursing Homes-Avg Mo Caseload SFY 11 (1st quarter)	9,961
FE / PD / TBI COMMUNITY SERVICES	
FE WAIVER ~ number served at start of SFY 2011	5,813
PD WAIVER ~ number served at start of SFY 2011	6,927
TBI WAIVER ~ number served at start of SFY 201	377
FE MFP ~ number joining into this program throughout the 1st quarter of SFY 2011	19
PD MFP ~ number joining into this program throughout the 1st quarter of SFY 2011	37
TBI MFP ~ number joining into this program throughout the 1st quarter of SFY 2011	2
SUBTOTAL FE	5,832
SUBTOTAL PD	6,964
SUBTOTAL TBI	379
Change due to OTHER reasons FE Waiver (1st quarter)	81
Change due to OTHER reasons PD Waiver (1st quarter)	97
Change due to OTHER reasons TBI Waiver (1st quarter)	38
SUBTOTAL FE	5,913
SUBTOTAL PD	7,061
SUBTOTAL TBI	417
Total Net Changes FE/PD/TBI Waivers	274
Total Net Changes FE/PD/TBI Waivers and Institutional	-207
GRAND TOTAL NET CHANGES ALL SYSTEMS – DD/FE/PD/TBI HCBS and INSTITUTIONAL	-118

Attachment A

Osawatomie State Hospital							
State Fiscal Year	Admissions	Average Daily Census	High Census	Low Census	Days Over Census	Per Cent Days Over Census	Average Length of Stay
2005	1,943	167	193	136	74	20%	31
2006	2,016	166	198	134	81	22%	29
2007	1,969	170	199	150	100	28%	28
2008	2,181	169	195	145	64	17%	25
2009	2,042	169	195	145	82	23%	30
2010	2,193	172	197	142	123	34%	29

Rainbow Mental Health Facility							
State Fiscal Year	Admissions Adult & Youth	Average Daily Census Adult Only	High Census Adult Only	Low Census Adult Only	Days Over Census	Per Cent Days Over Census	Average Length of Stay Adult Only
2005	671	24	40	3	76	21%	21
2006	664	26	41	10	52	14%	21
2007	671	30	40	20	19	5%	23
2008	810*	44	56	32	36	10%	19
2009	875	42	55	24	27	7%	17
2010	840	49	61	37	131	36%	22

* Stopped admitting children and adolescents. All children and adolescents are now served at KVC STAR.

Larned State Hospital Psychiatric Services Program							
State Fiscal Year	Admissions Adult & Youth	Average Daily Census Adult & Youth	High Census Adult Only	Low Census Adult Only	Days Over Census Adult Only	Percent Days Over Census Adult Only	Average Length of Stay Adult Only
2005	990	72	84	52	2	.5%	49
2006	1,064	81	86	59	31	8%	25
2007	1,097	82	92	56	34	9%	27
2008	1,177	94	102	71	259	71%	33
2009	1,071	86	99	63	141	39%	30
2010	1,223*	93	108	72	302**	83%	44

Note:

*Youth Services Closed May 6, 2010.

**Effective May 21, 2010, Psychiatric Services Program (PSP) capacity changed from 79 to 90, although the budgeted census remains at 79. The number above reflects days over our budgeted census of 79. There were 296 days or 81% of days over capacity.

Home and Community Based
Services Oversight
Date: 11-8-10
Attachment: #15

KANSAS
DEPARTMENT ON AGING

Joint Committee on Home and Community-Based Services Oversight

November 8, 2010

Quality Care Improvement

Martin Kennedy

Secretary of Aging

Kansas Department on Aging

Quality Care Improvement Panel Members
Governor's Appointees Pending

11/08/10

Name	Title	Company	City	State	Phone	Organization	Gov Appt
Ray Vernon	CEO	Wesley Towers	Hutchinson	KS	620-663-9175	KAHSA	
Kim Couri	Dir. Of Reimbursement	Good Samaritan Society	Sioux Falls	SD	605-362-3100	KAHSA	
						Consumer	X
Kim Hensely	Healthcare Quality Improvement Project Manager	Ks Foundation for Medical Care	Topeka	KS	785-271-4150	KFMC	
						KACE	X
Steve Hatlestad	Adminstrator	Americare	Olathe	KS	816-810-8881	KHCA	
Mike Tyron	Adminstrator	Midwest Health	Topeka	KS	785-272-1535	KHCA	
						KDOA	X
Mark Miller	CEO	Memorial Health System	Abilene	KS	785 263-6622	KHA	
						KHPA	X
Mitzi McFatrich	Executive Director	Kansas Advocates for Better Care	Lawrence	KS	785 842-3088	KABC	

KANSAS
DEPARTMENT ON AGING

Home and Community Based
Services Oversight
Date: 11-8-10
Attachment: # 16

Joint Committee on Home and Community-Based Services Oversight

November 8, 2010

PACE Projections

Bill McDaniel

Program and Policy Commissioner

Kansas Department on Aging

**PACE Expenditure Projections –
Via Christi**

Via Christi Hope

State Fiscal Year	Approved Slots	KDOA Budget Cap	Historical Participants	Actual/Projected Expenditures
7/1/2003	200		61	$510,949
7/1/2004	200		114	1,813,823
7/1/2005	200		165	2,846,269
7/1/2006	200		197	2,669,315
7/1/2007	200		193	2,974,146
7/1/2008	200		175	2,857,754
7/1/2009	275		175	2,855,852
7/1/2010	275		198	3,310,999
7/1/2011	275	**205**		**3,611,223**
7/1/2012	275	**241**		**4,130,306**

Midland Connections

	Approved Slots	KDOA Budget Cap	Historical Data	Actual/Projected
7/1/2007	50		14	$55,015
7/1/2008	75		28	387,879
7/1/2009	75		47	842,650
7/1/2010	105		80	1,220,146
7/1/2011	105	**100**	0	**1,489,005**
7/1/2012	105	**126**	0	**2,265,662**

PACE Combined

	Approved Slots	KDOA Budget Cap	Historical Participants	Actual/Projected
7/1/2003	200		61	$510,949
7/1/2004	200		114	1,813,823
7/1/2005	200		165	2,846,269
7/1/2006	200		197	2,669,315
7/1/2007	250		207	3,029,161
7/1/2008	275		203	3,245,634
7/1/2009	350		222	3,698,502
7/1/2010	380		278	4,531,144
7/1/2011	**380**	**305**	**305**	**5,100,228**
7/1/2012	**380**	**367**	**367**	**6,395,968**

PACE Expenditure Projections

FY 11	KDOA	KHPA	Patient Liability	Combined

Via Christi			Avg Caseload Growth		2					
Mo	Yr	Caseload	Δ	Avg Rt	Exp.	Avg Rt	Exp.	Avg Rt	Exp.	Avg Rt	Exp.
July	10	199	2	1,487	295,996	625	124,436	262	49,571	2,362	470,003
Aug	10	200	1	1,473	294,691	652	130,387	255	50,984	2,380	476,062
Sept	10	198	-2	1,484	293,764	677	133,967	232	46,015	2,393	473,746
Oct	10	198	0	1,481	293,320	691	136,886	230	45,505	2,403	475,711
Nov	10	200	2	1,492	298,400	586	117,200	262	52,400	2,340	468,000
Dec	10	202	2	1,492	301,384	586	118,372	262	52,924	2,340	472,680
Jan	11	204	2	1,492	304,368	586	119,544	262	53,448	2,340	477,360
Feb	11	205	1	1,492	305,860	586	120,130	262	53,710	2,340	479,700
Mar	11	205	0	1,492	305,860	586	120,130	262	53,710	2,340	479,700
Apr	11	205	0	1,492	305,860	586	120,130	262	53,710	2,340	479,700
May	11	205	0	1,492	305,860	586	120,130	262	53,710	2,340	479,700
Jun	11	205	0	1,492	305,860	586	120,130	262	53,710	2,340	479,700
Totals/Avgs		202	1	1,488	3,611,223	611	1,481,442	256	619,397	2,355	5,712,062

Midland			Avg Caseload Growth		3					
Mo	Yr	Caseload	Δ	Avg Rt	Exp.	Avg Rt	Exp.	Avg Rt	Exp.	Avg Rt	Exp.
July	10	79	3	1,418	112,021	410	32,407	267	21,103	2,095	165,531
Aug	10	73	-6	1,448	105,722	476	34,745	217	15,836	2,141	156,303
Sept	10	77	4	1,452	111,802	444	34,195	216	16,655	2,112	162,652
Oct	10	76	-1	1,454	110,520	448	34,068	210	15,973	2,113	160,561
Nov	10	79	3	1,465	115,735	425	33,575	221	17,459	2,111	166,769
Dec	10	82	3	1,465	120,130	425	34,850	221	18,122	2,111	173,102
Jan	11	85	3	1,465	124,525	425	36,125	221	18,785	2,111	179,435
Feb	11	88	3	1,465	128,920	425	37,400	221	19,448	2,111	185,768
Mar	11	91	3	1,465	133,315	425	38,675	221	20,111	2,111	192,101
Apr	11	94	3	1,465	137,710	425	39,950	221	20,774	2,111	198,434
May	11	97	3	1,465	142,105	425	41,225	221	21,437	2,111	204,767
Jun	11	100	3	1,465	146,500	425	42,500	221	22,100	2,111	211,100
Totals/Avgs		85	2	1,458	1,489,005	432	439,715	223	227,803	2,112	2,156,523

FY 11	KDOA	KHPA	Patient Liability	Combined

Combined			Avg Caseload Growth		5					
Mo	Yr	Caseload	Δ	Avg Rt	Exp.	Avg Rt	Exp.	Avg Rt	Exp.	Avg Rt	Exp.
July	10	278	5	1,468	408,017	564	156,843	254	70,674	2,286	635,534
Aug	10	273	-5	1,467	400,413	605	165,132	245	66,820	2,316	632,365
Sept	10	275	2	1,475	405,566	611	168,162	228	62,670	2,314	636,398
Oct	10	274	-1	1,474	403,840	624	170,954	224	61,478	2,322	636,272
Nov	10	279	5	1,484	414,135	540	150,775	250	69,859	2,275	634,769
Dec	10	284	5	1,484	421,514	540	153,222	250	71,046	2,274	645,782
Jan	10	289	5	1,484	428,893	539	155,669	250	72,233	2,273	656,795
Feb	10	293	4	1,484	434,780	538	157,530	250	73,158	2,271	665,468
Mar	10	296	3	1,484	439,175	537	158,805	249	73,821	2,270	671,801
Apr	10	299	3	1,484	443,570	535	160,080	249	74,484	2,268	678,134
May	10	302	3	1,483	447,965	534	161,355	249	75,147	2,266	684,467
Jun	10	305	3	1,483	452,360	533	162,630	249	75,810	2,265	690,800
Totals/Avgs		287	3	1,480	5,100,228	558	1,921,157	246	847,200	2,283	7,868,585

Total PACE Expenditures									
FY 11	Caseload	KDOA		KHPA		Patient Liability		Combined	
	287	1,480	5,100,228	558	1,921,157	246	847,200	2,283	7,868,585
			1,648,394						
		FMAP	0.3232						

FY 12	KDOA	KHPA	Patient Liability	Combined

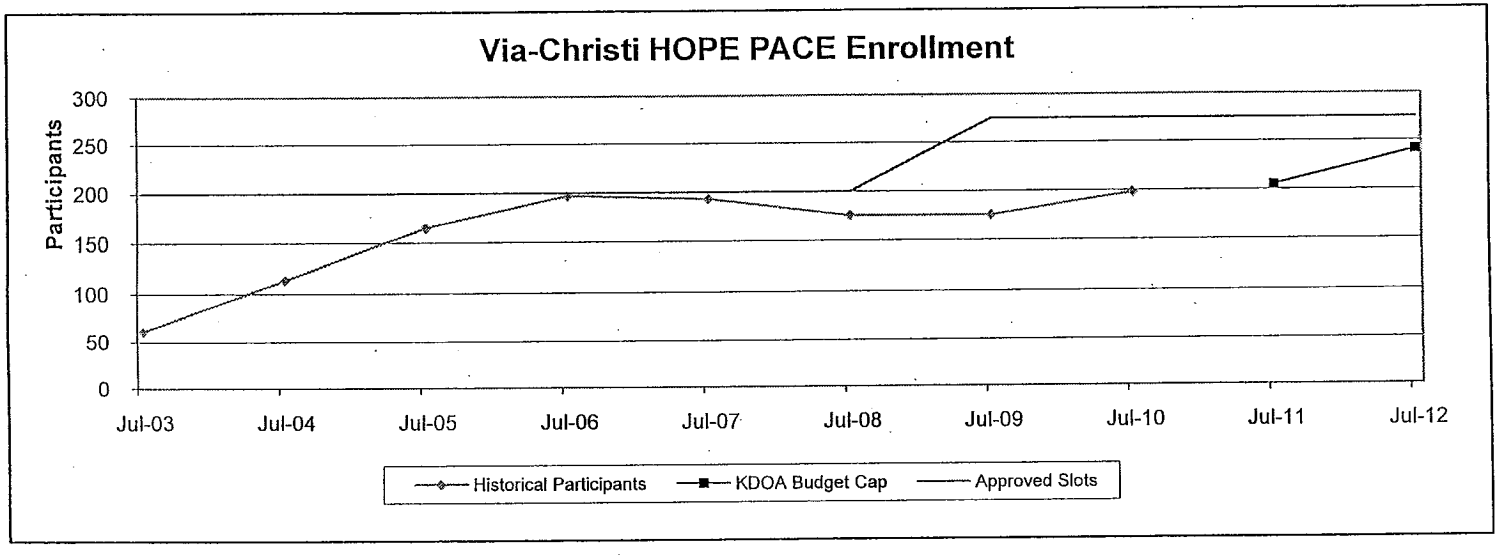
Via Christi			Avg Caseload Growth		3		Rate Increase		3.00%	
Mo	Yr	Caseload	Δ	Avg Rt	Exp.	Avg Rt	Exp.	Avg Rt	Exp.	Avg Rt	Exp.
July	11	208	3	1,533	318,895	629	130,922	256	53,302	2,419	503,119
Aug	11	211	3	1,533	323,495	629	132,810	256	54,071	2,419	510,376
Sept	11	214	3	1,533	328,094	629	134,698	256	54,840	2,419	517,633
Oct	11	217	3	1,533	332,694	629	136,587	256	55,609	2,419	524,889
Nov	11	220	3	1,533	337,293	629	138,475	256	56,378	2,419	532,146
Dec	11	223	3	1,533	341,892	629	140,363	256	57,146	2,419	539,402
Jan	12	226	3	1,533	346,492	629	142,252	256	57,915	2,419	546,659
Feb	12	229	3	1,533	351,091	629	144,140	256	58,684	2,419	553,915
Mar	12	232	3	1,533	355,691	629	146,028	256	59,453	2,419	561,172
Apr	12	235	3	1,533	360,290	629	147,916	256	60,222	2,419	568,428
May	12	238	3	1,533	364,890	629	149,805	256	60,990	2,419	575,685
Jun	12	241	3	1,533	369,489	629	151,693	256	61,759	2,419	582,941
Totals/Avgs		225	3	1,533	4,130,306	629	1,695,689	256	690,369	2,419	6,516,365

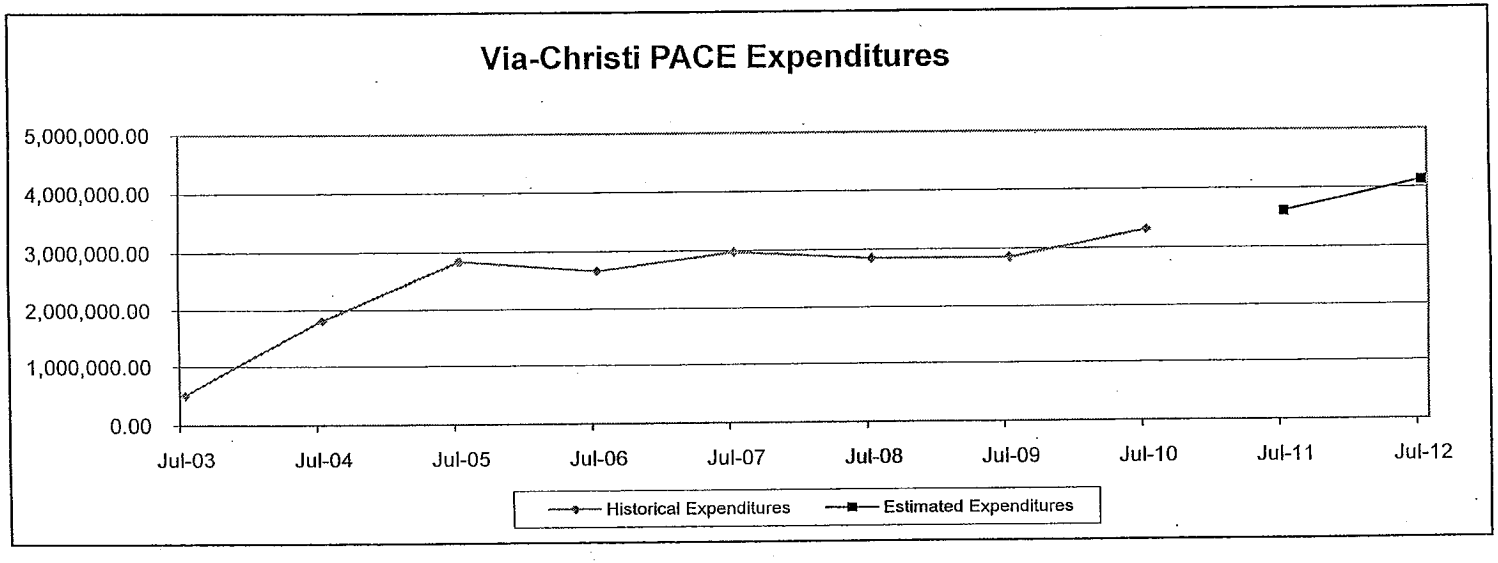
Midland			Avg Caseload Growth		4		Rate Increase		3.00%	
Mo	Yr	Caseload	Δ	Avg Rt	Exp.	Avg Rt	Exp.	Avg Rt	Exp.	Avg Rt	Exp.
July	10	104	4	1,501	156,149	432	44,881	223	23,214	2,156	224,243
Aug	10	108	4	1,501	162,155	432	46,607	223	24,107	2,156	232,868
Sept	10	112	4	1,501	168,160	432	48,333	223	25,000	2,156	241,493
Oct	10	116	4	1,501	174,166	432	50,059	223	25,892	2,156	250,118
Nov	10	120	4	1,501	180,172	432	51,785	223	26,785	2,156	258,742
Dec	10	124	4	1,501	186,178	432	53,511	223	27,678	2,156	267,367
Jan	11	128	4	1,501	192,183	432	55,238	223	28,571	2,156	275,992
Feb	11	132	4	1,501	198,189	432	56,964	223	29,464	2,156	284,617
Mar	11	136	4	1,501	204,195	432	58,690	223	30,357	2,156	293,241
Apr	11	140	4	1,501	210,201	432	60,416	223	31,249	2,156	301,866
May	11	144	4	1,501	216,206	432	62,142	223	32,142	2,156	310,491
Jun	11	145	1	1,501	217,708	432	62,574	223	32,366	2,156	312,647
Totals/Avgs		126	4	1,501	2,265,662	432	651,200	223	336,825	2,156	3,253,687

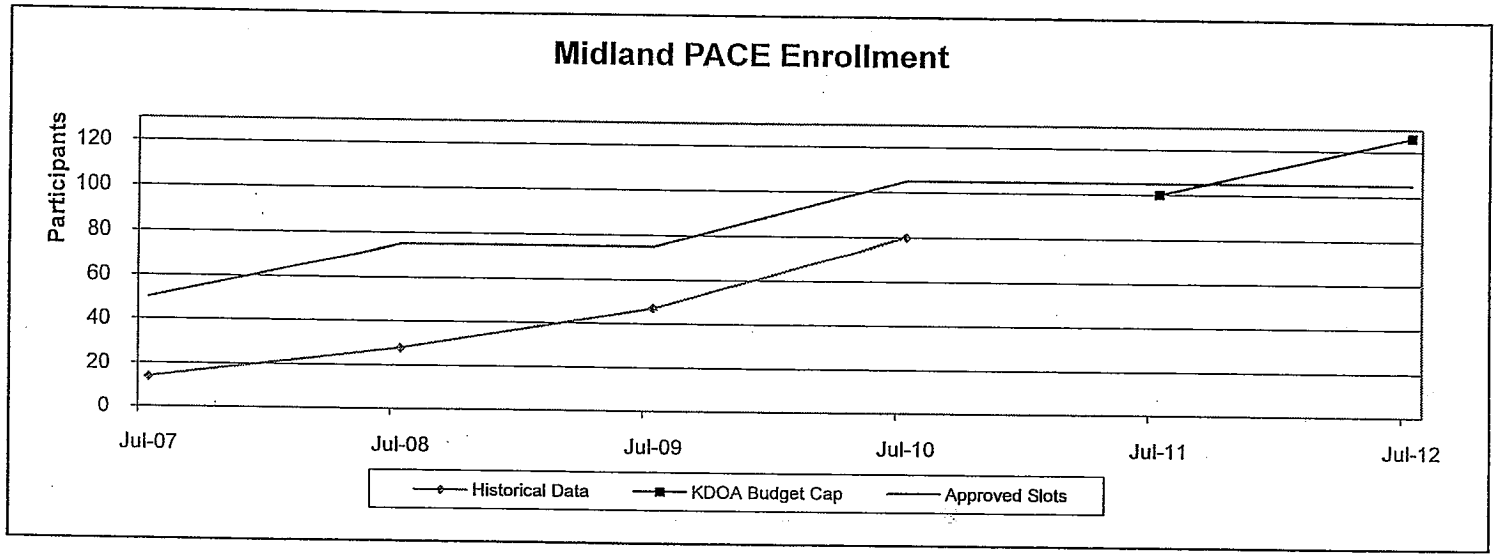
FY 11	KDOA	KHPA	Patient Liability	Combined

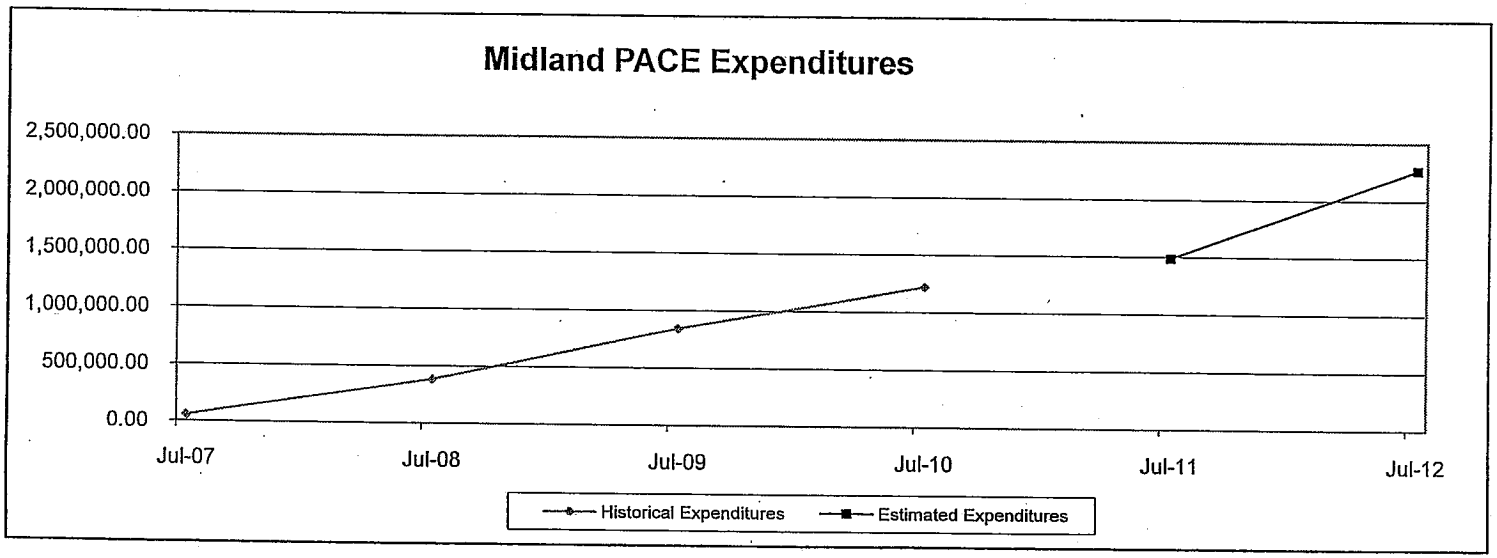
Combined			Avg Caseload Growth		7					
Mo	Yr	Caseload	Δ	Avg Rt	Exp.	Avg Rt	Exp.	Avg Rt	Exp.	Avg Rt	Exp.
July	10	312	7	1,523	475,044	563	175,802	245	76,516	2,331	727,363
Aug	10	319	7	1,522	485,649	562	179,417	245	78,178	2,330	743,244
Sept	10	326	7	1,522	496,255	561	183,031	245	79,840	2,329	759,126
Oct	10	333	7	1,522	506,860	560	186,646	245	81,501	2,327	775,007
Nov	10	340	7	1,522	517,465	560	190,260	245	83,163	2,326	790,888
Dec	10	347	7	1,522	528,070	559	193,875	244	84,825	2,325	806,769
Jan	10	354	7	1,522	538,675	558	197,489	244	86,486	2,324	822,651
Feb	10	361	7	1,522	549,280	557	201,104	244	88,148	2,323	838,532
Mar	10	368	7	1,521	559,886	556	204,718	244	89,809	2,322	854,413
Apr	10	375	7	1,521	570,491	556	208,333	244	91,471	2,321	870,294
May	10	382	7	1,521	581,096	555	211,947	244	93,133	2,320	886,176
Jun	10	386	4	1,521	587,197	555	214,267	244	94,125	2,320	895,588
Totals/Avgs		350	7	1,522	6,395,968	559	2,346,889	245	1,027,194	2,325	9,770,052

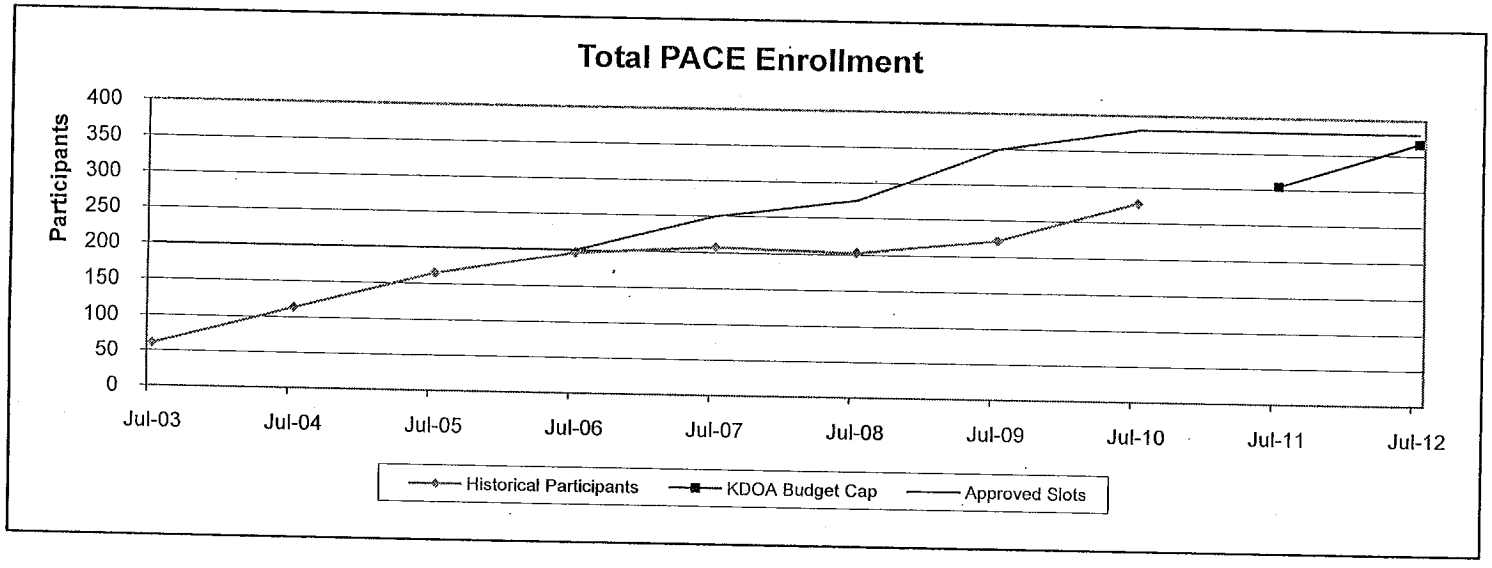
Total PACE Expenditures									
FY 12	Caseload	KDOA		KHPA		Patient Liability		Combined	
	350	1,522	6,395,968	559	2,346,889	245	1,027,194	2,325	9,770,052
			2,722,124						
		FMAP	0.4256						

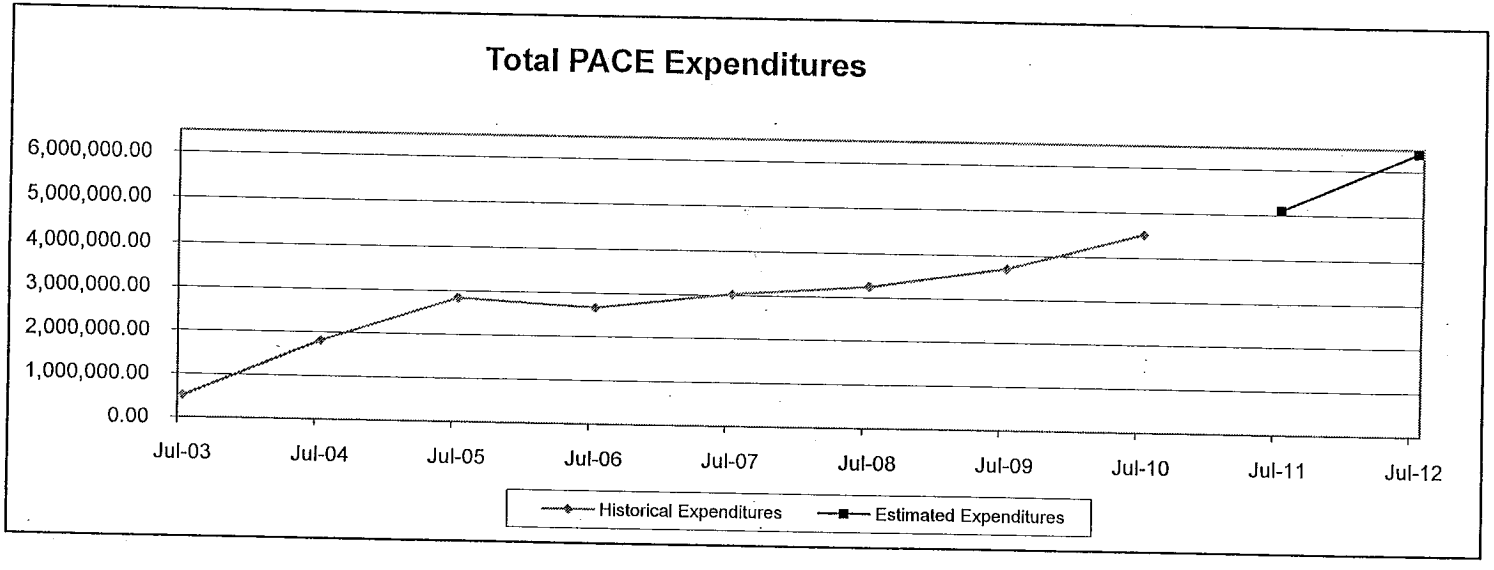

Via-Christi HOPE PACE Enrollment
Participants
300
250
200
150
100
50
0
Jul-03
Jul-04
Jul-05
Jul-06
Jul-07
Jul-08
Jul-09
Jul-10
Jul-11
Jul-12
Historical Participants
KDOA Budget Cap
Approved Slots


Via-Christi PACE Expenditures
5,000,000.00
4,000,000.00
3,000,000.00
2,000,000.00
1,000,000.00
0.00
Jul-03
Jul-04
Jul-05
Jul-06
Jul-07
Jul-08
Jul-09
Jul-10
Jul-11
Jul-12
Historical Expenditures
Estimated Expenditures


Midland PACE Enrollment
Participants
120
100
80
60
40
20
0
Jul-07
Jul-08
Jul-09
Jul-10
Jul-11
Jul-12
Historical Data
KDOA Budget Cap
Approved Slots


Midland PACE Expenditures
2,500,000.00
2,000,000.00
1,500,000.00
1,000,000.00
500,000.00
0.00
Jul-07
Jul-08
Jul-09
Jul-10
Jul-11
Jul-12
Historical Expenditures
Estimated Expenditures


Total PACE Enrollment
Participants
400
350
300
250
200
150
100
50
0
Jul-03
Jul-04
Jul-05
Jul-06
Jul-07
Jul-08
Jul-09
Jul-10
Jul-11
Jul-12
Historical Participants
KDOA Budget Cap
Approved Slots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5,000,000.00
4,000,000.00
3,000,000.00
2,000,000.00
1,000,000.00
0.00
Jul-03
Jul-04
Jul-05
Jul-06
Jul-07
Jul-08
Jul-09
Jul-10
Jul-11
Jul-12
Historical Expenditures
Estimated Expenditures

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Joint Committee on Home and Community Based Services Oversight
Update on HealthWave Clearinghouse Backlog

November 8, 2010

Scott Brunner
Chief Financial Officer
Kansas Health Policy Authority

Home and Community Based
Services Oversight
Date: 11-8-10
Attachment: #17

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State Employee Health Plan:
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State Self Insurance Fund:
Phone: 785-296-2364
Fax: 785-296-6995

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KANSAS HEALTH POLICY AUTHORITY

Joint Committee on Home and Community Based Services Oversight
November 8, 2010

Update on HealthWave Clearinghouse Backlog

Background: In January, 1999 Kansas began modernizing its public insurance program and, with the implementation of the Children's Health Insurance Program (CHIP or HealthWave 21), initiated a simplified application for enrolling children and extended the streamlined CHIP application process to low income families applying for Medicaid. Verification requirements were loosened and eligibility was extended to children for a full twelve months. To facilitate the streamlined application process, a centralized Clearinghouse was created to receive applications via a mail-in process. Beneficiaries in eligibility categories processed by the Clearinghouse now include 40,670 children enrolled in CHIP, 178,000 children enrolled in Medicaid, 7,500 pregnant women, and 20,000 low income adults enrolled in Medicaid. The Clearinghouse now processes 10,000 to 12,000 applications and renewals a month. The remaining eligibility work, including enrollment and maintenance of elderly and medical cases and child welfare cases, remain a function performed at local offices of the Department of Social and Rehabilitation Services (SRS).

Historical Clearinghouse Performance: The Clearinghouse is a centralized processing center which manages Family Medical eligibility determinations. The Clearinghouse is operated by a private vendor through a competitive contract. The contractor for the first ten years was Maximus and now is Policy Solutions Inc. (PSI). The Clearinghouse processes applications and renewals through a mail-in process. When an application is submitted, it is registered and then forwarded to an eligibility counselor for screening. The screening process determines if any additional information is needed and if so a letter is sent to the applicant requesting the missing information. The goal at the Clearinghouse is to process the applications quickly and accurately. According to federal regulations an eligibility determination must be completed on an application within 45 days of the date it is received. Medical emergency and pregnancy related applications receive first priority for processing. On average, the Clearinghouse processed applications in less than a month prior to the institution of the new federal Medicaid citizenship and identification documentation requirements in 2006.

New federal citizenship requirements went into effect on July 1, 2006 requiring all Medicaid applicants to provide adequate documentation of citizenship and identity. The requirement of additional documentation for every applicant significantly altered the Clearinghouse application process for medical benefits. By January, 2007 a significant backlog of applications had developed, with a corresponding decline of 18,000-20,000 individuals enrolled in Kansas Medicaid and CHIP programs. KHPA made a FY 2007 supplemental budget request and a FY 2008 enhancement budget request to add staff to the Clearinghouse. The requests were approved by the legislature, and the additional

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Fax: 785-296-6995

funds were used to add 13 contract and 4 state staff. By January, 2008 applications and reviews were being fully processed within 25 days of receipt.

Contributors to Current Clearinghouse Backlog Situation: Beginning in calendar year 2009 and continuing into 2010 a number of factors converged to create a large new backlog, including:

- Increased volume of Kansans applying for Medicaid and CHIP due to economic climate
- Expiration of the HealthWave Clearinghouse contract resulting in new procurement and transition of functions from Maximus to PSI between June 2009 and January 2010
- Federal citizenship documentation requirement extended to CHIP on January 1, 2010
- Expansion of CHIP eligibility to 250% of the 2008 federal poverty level
- November 2009 Governor's Allotments resulting in a reduction of $430,000 SGF, $981,538 AF in the PSI contract
- PSI startup performance inefficiencies

Efforts to Address the Backlog. Since 2009, KHPA has taken a number of steps to find a solution to the backlog of applications and the resulting delays in eligibility experienced by thousands of applicants. In August 2009 KHPA began applying approximately $450,000 AF unexpectedly returned from a former contractor to increased overtime at the Clearinghouse. Nevertheless, as a result of the Governor's November 2009 allotment those funds had to be reapplied to other agency operations. In late 2009 and 2010 KHPA engaged in extended discussions with private donors interested in helping to reduce the backlog. Due to CMS restrictions, donations from individual Medicaid providers were limited. Nevertheless, the agency received a total of $55,000 in provider donations during FY 2010, all of which were applied to overtime for Clearinghouse staff. Beginning January, 2010, KHPA extended Medicaid and CHIP coverage for two months past the normal 12 month review redetermination. Also, in an effort to mitigate the impact of these factors on the processing of Medicaid and CHIP applications, KHPA has twice simplified the eligibility process. The first set of eligibility simplification policies were put in place January 1, 2010 and included: self-declaration of child support, elimination of trust test for "Caretaker Medical", self-declaration of pregnancy, elimination of mid-year reporting for Transitional Medical recipients, continuous 12-month eligibility for caretaker medical, change of income calculation for new applicants with jobs, and increased reliance on Department of Labor wage information. KHPA also identified several areas of performance inefficiency on the part of our Clearinghouse contractor, PSI and in addition to invoking contract penalty provisions the agency has proportioned the volume of the backlog to be attributed to PSI performance inefficiencies (8734) and assigned them sole responsibility for timely processing of those applications to them. As of October, 2010, at no additional charge to the state PSI has added 23 additional staff dedicated to processing their portion of the backlogged applications. KHPA has worked diligently in collaboration with PSI to find multidimensional approaches to reduce the backlog but despite these efforts, the backlog remained very large, prompting a federal response in mid-2010.

Addressing Centers for Medicare and Medicaid (CMS) Concerns: On April 22, 2010 KHPA received a letter from James Scott, Associate Regional Administrator for Medicaid and Children's Health Operations for CMS. In the letter, CMS noted that Kansas was out of compliance with its state Medicaid plan and with federal requirements regarding timely determination of eligibility. As a result, CMS requested the filing of a corrective action plan outlining how Kansas planned to resolve the issue. On July 30, 2010 KHPA sent to CMS the corrective action plan to resolve the HealthWave Clearinghouse backlog which employs a three-pronged approach:

- Implement system modifications to hasten the processing of applications. Many of the system enhancements have already been implemented as of November 2010. For example:

- The system's functionality has been improved by adding keyboard shortcuts, hot keys, and better search capabilities within the system;
- The system was enhanced to enable workers to make multiple month determinations at one time.
- Implementation of a single screen to create cases
- Elimination of duplicate entry by allowing entry of a case into a single system (PSI's) and transferring it to the state's eligibility system (KAECSES) overnight.

- Adopt CMS approved eligibility policy options to simplify the eligibility determination process: This represents the second wave of eligibility simplifications designed to reduce administrative burden at the Clearinghouse (and for beneficiaries). These simplifications include: KHPA will be accepting self-declaration of income; state staff will do minimum verification of the contractor's work prior to authorizing Medicaid eligibility; parents will be allowed to apply for children 18 years of age; KHPA and its contractor will perform eligibility determination only for those individuals who request coverage on the application; KHPA will initiate in phases the Express Lane eligibility option-targeting food stamp recipients first; KHPA will pursue the establishment of access to the SSA electronic verification system to confirm the declaration of citizenship with SSA records in lieu of the current presentation of citizenship documentation; KHPA will also utilize a newly developed pre-populated review form for adult beneficiaries seeking to renew their HealthWave eligibility and implement passive review determinations for child beneficiaries renewing their HealthWave eligibility. KHPA plans to fully implement these eligibility simplification policies by February 2011.

- KHPA will continue to seek financial resources from multiple sources to increase application processing capacity. Strategies include seeking private funding from philanthropic foundations, submitting budget enhancement requests to the governor and legislature and seeking a favorable CHIPRA bonus payment decision.

Current Status of HealthWave Clearinghouse Backlog: On August 11, 2010 KHPA was notified by CMS that Kansas had been awarded a $1,220.479 CHIPRA bonus award. The CHIPRA performance bonuses were included in the Children's Health Insurance Program Reauthorization law to recognize states for making significant progress in enrolling children in health coverage through Medicaid and the state children's health insurance program. Kansas was one of only ten states who received bonuses tied to the achievement of enrollment targets and improvements in the eligibility process. Kansas qualified through adoption of 12-month continuous coverage, liberalization of asset requirements, elimination of the face-to-face interview, use of a joint application for Medicaid and CHIP, and presumptive eligibility. With sufficient funding to fully implement the corrective action plan for CMS, KHPA committed to resolve the backlog within six months, i.e., by March 2011.

In the month following receipt of funding through the CHIPRA bonus, 16 temporary workers were hired as staff for the eligibility Clearinghouse. They began training on September 20, 2010. In addition, further system enhancements were implemented in September and a number of simplifications to the eligibility determination process were adopted including, streamlined verification of the contractor work, piloting of the pre-populated review form for adult beneficiaries to renew their eligibility, and exploration of implementation of the interface with SSA to confirm citizenship declaration. On October 25, 2010, KHPA initiated passive renewals for child Medicaid and CHIP beneficiaries. Over the last month the additional resources coupled with changes in policies have resulted in an increase of 5000 applications/reviews processed and a retirement of 1500 over 45

days applications from the backlog Table 1). As of November 1, the backlog numbers 17, 786 over 45 days but KHPA is now on track to resolve it by March 2011.

Figure 1

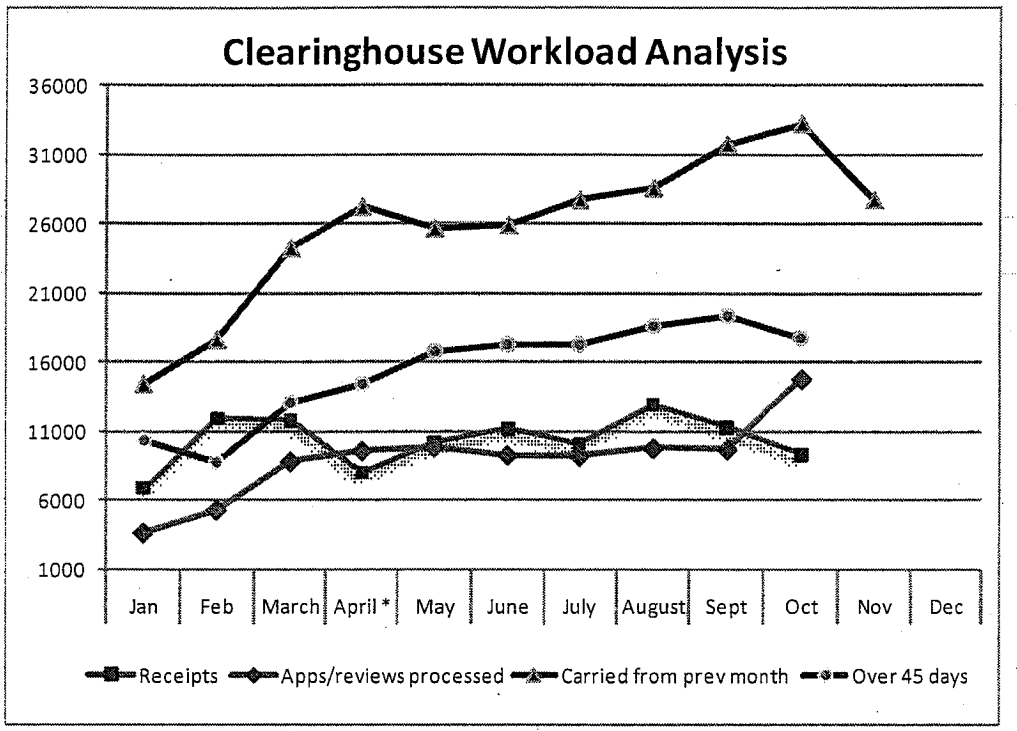


Table 1

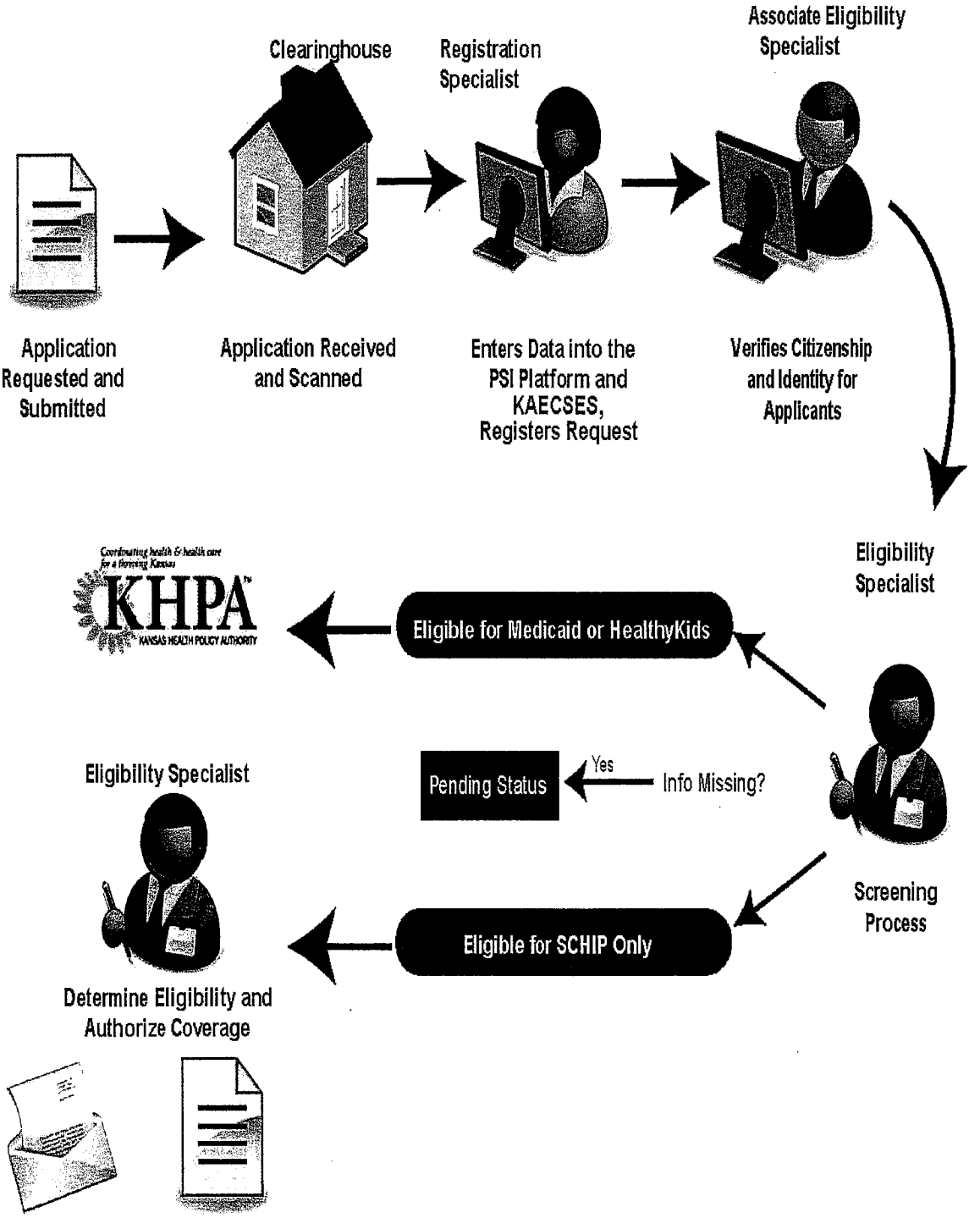
	Jan	Feb	March	April *	May	June	July	August	Sept	Oct **	Nov	Dec	Totals
Carried from prev month	14,379	17,639	24,285	27,243	25,659	25,919	27,753	28,582	31,735	33,272	28,889		
Receipts Apps/reviews	6,902	11,969	11,810	8,015	10,146	11,132	10,026	12,965	11,250	10,438			**104,653**
Apps/reviews processed	3,642	5,323	8,843	9,599	9,886	9,298	9,197	9,812	9,713	14,821			**90,134**
Over 45 days	10,406	8,710	13,066	14,442	16,816	17,259	17,303	18,687	19,336	17,786			

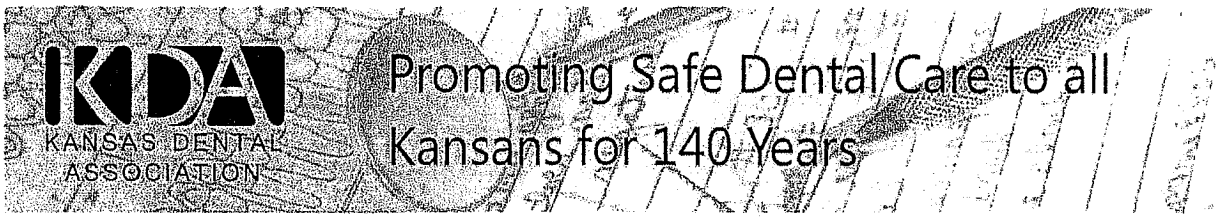
* Numbers reflect Impact of the implementation of the 60 days extension for all reviews resulting in the number of reviews received per month to drop.

** Numbers reflect the addition of 16 staff as of 9/27/2010

11/2/2010

Presented to Joint Committee on Home and Community Based Services Oversight
November 8, 2010





November 23, 2010

Representative Bob Bethell, Chairman
Joint Committee on HCBS Oversight
300 SW 10th, Room 68-West
Topeka, KS 66612

Dear Chairman Bethell and members of the Joint Committee on HCBS Oversight,

Thank you for the opportunity to clarify my remarks to the Committee regarding Expanded Scope of Services for Dental Hygienists on Monday, November 8th. In my testimony concerning dental Medicaid I stated that ***"the provider agreement is 180 pages long!"***

This is information that I had received directly from a Medicaid provider dentist and took as fact without independently verifying it before including it in my comments. Following the testimony I discovered that this information is not entirely accurate and I apologize to the Committee for any misunderstanding this may have caused.

The entire dental provider documents consist of 184-pages...a 21-page application/agreement plus the KMAP Dental Provider Policy Manual which is an additional 163-pages including exhibits, attachments, etc. The Provider Agreement includes the Dental Provider Manual is via reference in section 1 of the agreement. These are included for the Committee's information

Thank you for the opportunity to clarify my statement. I apologize if I created any confusion over this matter and I will be sure to correctly state this information in any future comments regarding Medicaid.

Sincerely,

Kevin J. Robertson, CAE
Executive Director

Enclosures

5200 SW Huntoon, Topeka, KS 66604 • 785.272.7360 • kevin@ksdental.org

Home and Community Based
Services Oversight
Date: 11-8-10
Attachment: #18