Report of the Joint Committee on Health Policy Oversight to the 2012 Kansas Legislature

CHAIRPERSON: Senator Vicki Schmidt

VICE-CHAIRPERSON: Representative Brenda Landwehr

OTHER MEMBERS: Senators Pete Brungardt, David Haley, Laura Kelly, Roger Reitz, and Ruth Teichman; and Representatives Don Hill, Peggy Mast, Susan Mosier, Louis Ruiz, and Jim Ward

CHARGE

- The Committee has the exclusive responsibility to monitor and study the operations of the Kansas Health Policy Authority. In addition, the Committee is responsible for overseeing the implementation and operation of the children's health insurance plans, including the assessment of performance-based measurable outcomes as set out in statute.

December 2011

Joint Committee on Health Policy Oversight

Report

Conclusions and Recommendations

Based on the testimony heard and Committee deliberations, the Joint Committee on Health Policy Oversight reached the following conclusions and made the following recommendations:

- Encourage consideration of a close review of managed care contracts, prior to funds being appropriated by the Legislature, to ensure contracts stipulate that no cuts in Medicaid reimbursement rates will be made.
- Recognize the work of the Kansas Insurance Department in continuing the planning process for a health insurance exchange.
- Encourage all state agencies to pursue all available federal funds to assist in the development of a Kansas-run health insurance exchange. (Representative Landwehr and Representative Mast requested their opposition to this recommendation be noted in the Committee Report.)
- The Social and Rehabilitation Services (SRS) Secretary stated he would pursue funding for the SRS offices proposed for closure that remain open as a result of contracts between SRS and local government entities. The Committee would request that a status update be provided by SRS on the pursuit of funding for these offices.
- Encourage the Kansas Department of Health and Environment to consider exploring funding options for the Newborn Screening Program and to consider presenting to the 2012 Legislature any legislation needed to address the funding needs or changes.
- Request that the Committee annually address the issue of infant mortality so as to remain informed with regard to the state's infant mortality rate; obtain data comparing the state's rate with those of other states and the national rate; and consider the nature of the rate as it pertains to factors such as culture, race, and urban and rural populations.
- Encourage further consideration of expansion of the Medicaid program to include adult dental services.
- Consider supporting the Kansas University School of Medicine program's need for a new medical education building to replace the present facility, the plans to create a school of public health focusing on preventative medicine, and the development of individual in-home monitoring services through telemedicine; and to consider funds necessary to accomplish these plans.

- Consider reviewing the medical student loan program for possible incentives to encourage the practice of medicine in underserved areas of the state.

Proposed Legislation: The Committee recommends legislation be presented during the 2012 Legislative Session to amend the authorizing statute (KSA 2011 Supp. 46-3501) for the Joint Committee Health Policy Oversight by replacing the references to the "Kansas Health Policy Authority" with the "Division of Health Care Finance within the Kansas Department of Health and Environment" and to amend the statute to include oversight of general state health care policies. The Committee also recommends that the sunset date be changed to July 1, 2017.

The Committee further recommends a trailer bill be presented during the 2012 Legislative Session to make needed statutory changes resulting from Executive Reorganization Order No. 38, which was passed during the 2011 Legislative Session. The trailer bill makes no policy changes and is to accompany legislation to be presented amending the Committee's authorizing statute.

Background

The Joint Committee on Health Policy Oversight operates pursuant to KSA 46-3501. The 2005 legislation that created the Committee also established the Kansas Health Policy Authority (KHPA) and transferred certain health-related functions to the new agency. The Committee is composed of 12 members: six from the Senate and six from the House of Representatives. Each member serves a two-year term ending on the first day of the regular legislative session commencing in odd-numbered years. The Oversight Committee is authorized to introduce legislation.

The Oversight Committee is charged with monitoring and studying the operations and decisions of KHPA. KHPA was charged by law with improving the health of the people of Kansas by increasing the quality, efficiency, and effectiveness of health services and public health programs. In addition, as part of 2008 House Substitute for SB 81, the Oversight Committee is charged with the responsibility to oversee the implementation and operation of the state's children's health insurance plans, including the assessment of the performance-based measurable outcomes as set out in subsection (b)(4) of KSA 38-2001. The legislation creating the Oversight Committee expires on July 1, 2013.

The KHPA was abolished effective July 1, 2011, pursuant to Executive Reorganization Order No. 38 (ERO No. 38), which passed during the 2011 Legislative Session. The Executive Order transferred all powers, duties and functions of the KHPA to the Division of Health Care Finance within the Kansas Department of Health and Environment (KDHE).

Committee Activities

The Oversight Committee held three days of meetings during the 2011 Interim (September 19; October 25; November 15). The Committee considered the following topics: KanCare, the Kansas Medicaid Reform Plan, the resulting reorganization of departments within state government, and managed care; Medicaid provider rates; the return of the Early Innovator Grant and the status of the health insurance exchange; the Kansas Medical Eligibility (K-MED) System and the Kansas Eligibility Enforcement (KEES) System; the closure of several Social and Rehabilitation Services (SRS) community service centers; SRS information

release form concerns; Newborn Screening; an update on safety net clinics and federally qualified health centers; access to dental care; an update on the University of Kansas Schools of Medicine in Kansas City, Wichita and Salina, the Smoky Hill Family Residency Program in Salina, and the school's application for National Cancer Center Institute (NCI) designation as a national cancer center; the KHPA transition into the Division of Health Care Finance within KDHE; a change in the Committee's authorizing legislation; a trailer bill to address statutory changes needed as a result of ERO No. 38; and the Fall Human Services Consensus Caseload Estimates for Fiscal Years 2012 and 2013. The Committee made specific recommendations on the following topics.

Kansas Medicaid Reform, State Agency Reorganization, and Managed Care

The Committee received testimony from Lieutenant Governor Jeff Colyer at the September 19 meeting on the status of the state Medicaid reform plan; he again appeared before the Committee on November 15 to outline KanCare, the Kansas Medicaid Reform Plan.

At the September 19 meeting, the Committee heard from the Lieutenant Governor that the federal government would be announcing a $72 billion cut to Medicaid over the next ten years, which roughly translates to a $720 million federal cut to Kansas over the next several years, along with possible larger Medicaid cuts overall. He further indicated these federal cuts, with minimum flexibility for states, are all but certain and that Kansas must be prepared.

The Lieutenant Governor noted that Medicaid has a complex relationship between the federal and state governments, patients, insurers, and providers, and that current costs will overwhelm Kansas. According to the Lieutenant Governor, the state can expect a 400 percent increase in Medicaid expenditures in the next 20 years. The Governor's office solicited ideas for reforms or pilots to improve quality and control costs by holding public forums, Web surveys, and conferences.

The Medicaid transformation principles considered in creating the KanCare Plan were outlined by the Lieutenant Governor in his September 19 presentation. He also stated there is a need for a global waiver; some states have had success in initiating this in a limited fashion. The Lieutenant Governor stated that Kansas needs to take responsibility for the design of such a program, to allow Kansas solutions for Kansas problems and eliminate multiple waivers obtained from various agencies. He stressed caring for the whole person, promoting personal responsibility, and providing coordinated and value care to achieve better outcomes and to save money.

Committee members expressed concern about the possibility of provider rate cuts in managed care contracts. In his September 19 presentation before the Committee, the Lieutenant Governor said cutting provider rates would be the last thing the Administration would do, and that the Administration was trying not to cut the care required by individuals. Further, the Lieutenant Governor noted the state would not set rates, but would work with intermediaries. He acknowledged this would be a challenge, considering the different demographics of the state. When asked by the Committee member if the Legislature could set provider rates, the Lieutenant Governor said the state could do so, but intermediaries would set protective barriers that would be fair to everyone.

A Kansas Legislative Research Department staff member reviewed the Medicaid Provider rate reduction process at the October 25 meeting. He explained that two models are used for rate-payer programs, nationally: a state determined rate system and a uniform rate-for-services model governed by state guidelines. In order to contain costs, 25 states or territories have reduced provider payments; 34 states or

territories have proposed reducing provider payments in 2012; 15 states froze payments in 2011; and 16 states have proposed a freeze in 2012. In addition, on October 3, 2011, the U.S. Supreme Court heard a consolidated California case dealing with Medicaid cuts. The Court has not announced a decision date.

The SRS Secretary stated at the October 25 meeting that SRS will not cut Medicaid provider rates for the current fiscal year, even with reductions in agency appropriations and the limited options governed by federal restrictions.

The Lieutenant Governor again appeared before the Committee on November 15 to discuss the recently revealed Kansas Medicaid Reform Plan. Highlights of the plan are addressed in this report, with additional details in the November 15 minutes and attachments.

In describing the plan, the Lieutenant Governor shared the following key points:

- Kansas would seek a global waiver from the federal government to maximize flexibility in administering the Medicaid program;

- A comprehensive, integrated, person-centered care coordination program would be created, to be named "KanCare," which includes all major populations and services (including those currently provided in fee-for-service, existing managed care, home and community based services, and long-term and institutional care). As part of the KanCare program, the state would leverage private sector innovation to achieve public goals by issuing a Request for Proposal (RFP) targeting three statewide KanCare contracts. The KanCare Request for Proposal (RFP) would encourage contractors to use established community partners, including hospitals, physicians, Community Mental Health Centers (CMHCs), primary care and safety net clinics, Centers for Independent Living (CILs), Area Agencies on Aging (AAAs), and Community Developmental Disability Organizations (CDDOs). Safeguards for provider reimbursement and quality also would be included.

- "Off ramps" or transitions to private insurance coverage for Kansans currently on Medicaid would be created, including a Consolidated Omnibus Budget Reconciliation Act-like (COBRA) option, and health savings accounts that can be used to pay private-sector health insurance premiums. These reforms would aid in the transition from Medicaid to independence while preserving relationships with providers. Legislation may be needed to accomplish this aspect of the plan.

- Another element of the reform would be to increase opportunities to work, particularly for the disabled Kansans on Medicaid who have indicated their desire to find employment. An enhanced Medicaid to Work program would include collaboration with the Department of Commerce to match potential workers with employers.

- Public interaction with the Medicaid program would be streamlined by an agency realignment that would consolidate Medicaid fiscal and contractual management in KDHE and Home and Community Based Services (HCBS) waivers and mental health program management in a reconfigured Kansas Department on Aging (KDOA), to be renamed the Kansas Department for Aging and Human Services. The Department on Social and Rehabilitation Services (SRS) would add select family preservation, social and prevention programs from KDHE and the Juvenile Justice Authority (JJA) to strengthen its targeted focus as a renamed Department for Children and Families Services.

- Based on a conservative baseline of 6.6 percent growth in Medicaid without reforms (actual historic growth rate over the past decade was 7.4 percent), the outcomes-focused, person-centered care coordination model executed under the RFP is expected to achieve savings of $853 million (all funds) over the next five years.

- The Lieutenant Governor also discussed the Pay for Performance (P4P) measures to incentivize high performance and quality health outcomes. Five percent of each contractor's total per member, per-month payments would be held back each year for the purpose of incentive payments in years two and three. If the contractor meets quality benchmarks established by the State for each of the 15 selected P4P indicators, the contractor would receive the five percent back in full. The P4P indicators (five each for physical health, behavioral health, and long-term care) are detailed in the November 15 Committee minutes.

The Lieutenant Governor shared the principles used by the current administration to guide them in Medicaid reform, as they felt the present system was not acceptable.

Lieutenant Governor Colyer addressed Committee member concerns about how the Medicaid reform plan would achieve the savings indicated and whether the expected savings are realistic. He stated, in order for the managed care company to receive the five percent in payments which would be held back, they would need to work with the local physicians to improve health outcomes. Improved health outcomes would result in savings. Savings also would be achieved in the P4P program, wellness program, and HCBS. Further, when individuals receiving assistance through the Physical Disability/Developmental Disability (PD/DD) waiver become employed, those on the waiting list would be able to receive services. The Lieutenant Governor noted Optimus, the actuarial firm reviewing the plan, showed a more significant savings than those being presented by the Administration. He stated the savings amount claimed is not based on obtaining a global waiver. The state also would be seeking other waivers, including an "1115 waiver," which is completed in a manner being encouraged by the federal government. Centers for Medicare and Medicaid (CMS) approval is required for this waiver.

The SRS Secretary provided testimony regarding the impact of the reorganization of SRS under the Medicaid Reform Plan. The new SRS responsibilities, which would transfer from KDHE, include: licensing of child care facilities and foster care homes; providing infant-toddler services; providing services to children and youth with special needs; and continuing the Maternal, Infant and Early Childhood Home Visitor Program, the Pregnancy Maintenance Initiative, abstinence education, the Healthy Families program, and teen pregnancy prevention efforts.

In addition, SRS would be taking over prevention and intake-and-assessment functions from JJA. The Secretary stated the JJA services go hand-in-hand with the mission of SRS. Currently, the purpose of JJA is to "promote public safety by holding youth accountable for their behavior, and improve the ability of youth to live productively and responsibly in their communities." He noted SRS can better accomplish its mission to protect children and promote adult self-sufficiency by having a hand in the lives of juveniles and the process they must follow.

The SRS Secretary also indicated savings could be obtained by addressing incidents of fraud. SRS is going to be more aggressive with fraud concerning Vision cards. SRS intends to hire additional investigators and implement a program where if a Vision card is lost three times, the individual would be unable to receive a replacement card until a visit to the SRS office is made to explain the loss. SRS also would work

with individuals if the repeated card loss is a result of a disability or mental health issue.

The Kansas Department on Aging (KDOA) Secretary shared the reasons for the proposed reorganization with the Committee and provided a proposed KDOA organizational chart showing six departments within the newly proposed Department for Aging and Human Services. The departments would be: the Office of the Secretary; Financial and Information Services, State Hospitals; Regulatory Services; Division on Aging; and Community Services and Supports (Waiver Services and Mental Health/ Substance Abuse).

In response to Committee questions regarding the potential need for space for KDOA if the reorganization took place, the Secretary indicated that was yet to be determined. He stated the proposed reorganization would begin with the introduction of an Executive Reorganization Order within the first 30 days of the 2012 Legislative Session, with a proposed effective date of July 1, 2012.

A Committee inquiry regarding the status of the repairs at the Rainbow Mental Health Center was addressed by the SRS Secretary. The Secretary had previously told the Committee that the Fire Marshal had ordered safety updates for the Rainbow Mental Health Facility in Kansas City. Most residents would be transferred to a vacant facility in Osawatomie. He stated that SRS had no plans to close Rainbow. He indicated some patients already have been moved, with repairs to begin soon and to take six to eight months. He further stated that Rainbow would remain open, and eight beds would remain available on the site for emergency situations occurring during the renovation process.

The KDHE Secretary reviewed the impact of the reorganization on KDHE. With the approval of the proposed reorganization, KDHE would consist of the following four divisions: Operations (Office of the Secretary, Communications. Management and Budget, Information Technology and Legal Services); the Division of Public Health (Center for Health Disparities, Center for Performance Management, Community Health Systems, Oral Health, Disease Prevention and Control, Environmental Health, Health Promotion, Epidemiology and Public Health Informatics); the Division of Health Care Finance (Responsible for KanCare fiscal and contract management, State Employee Health Plan); and Division of Environment (Air, Waste Management, Water, Environmental Remediation, Environmental Field Services, Health and Environmental Laboratories). Health regulatory functions would move to the Department for Aging and Human Services. KanCare fiscal and contract management would move to the KDHE Division of Health Care Finance (DHCF).

Health Insurance Exchange and Return of the Early Innovator Grant

During the September 19 meeting, the Committee heard testimony from the Kansas Insurance Commissioner on the status of the health insurance exchange and the impact of the return of the Early Innovator Grant. The Commissioner discussed the major provisions of the Patient Protection and Affordable Care Act (ACA), enacted by Congress in March 2010, requiring the creation of health insurance exchanges that are to be operational in all states by January 1, 2014. Under the ACA, exchanges may be developed and operated by a state or the federal government. In 2010, the Department of Health and Human Services (HHS) offered states an opportunity to apply for a $1 million Exchange Planning Grant. The Kansas Insurance Department applied for and was awarded one of these grants and determined the exchange should be developed and operated by Kansans.

The Commissioner noted that, in December 2010, the Kansas Insurance Department was encouraged to work with representatives of KHPA to apply for an "Early Innovator" grant. This

additional grant was available to a small number of states who were in a position to begin working on the development of the IT infrastructure that would be required to support an exchange. Since KHPA had been working on plans for a new eligibility and enrollment system, the Insurance Department applied for and was awarded a grant in the amount of $31.5 million.

Under the Early Innovator Grant, the Commissioner stated that nearly $30 million of the funding was to be used for the Kansas Medical Eligibility Determination project (K-MED), with the remaining $1.5 million to be used for exchange integration. Planning for K-MED began immediately and continued until August 9, 2011, when Governor Brownback announced the return of the Early Innovator grant.

According to the Commissioner, as of September 2011, the Insurance Department had spent approximately 28 percent of the $1 million Planning Grant. If the decision was made to move forward with a state-operated exchange, additional funding would be needed to complete the work. HHS is providing states with the opportunity to apply for Level I and Level II Establishment Grants for continuation of planning and development. There are no specific dollar limits for these grants.

When the Commissioner was asked if she had seen any actuarial numbers for rates, she said the rates would depend on the essential benefits package and benefits are another area requiring a state decision. If the benefits for the state are more extensive than is required by the federal government, then the state would have to pay the additional cost. Federal law states that to be on an exchange of which there are four levels (bronze, silver, gold, and platinum), the state would have to offer at least two levels. When asked what the impact on the state exchange would be if people chose not to purchase insurance, the Commissioner stated the more participants the exchange has, the more the cost can be spread across the board.

The Commissioner appeared on November 15, 2011, to provide an update on the health insurance exchange. She updated the Committee regarding information recently obtained on the Federally Facilitated Exchange (FFE) and the State/Federal Partnership Model Exchange. At a meeting in September, hosted by Health and Human Services (HHS), officials provided information to states regarding the federal government's vision for a Federally Facilitated Exchange and a State/Federal Partnership Model. In that presentation, HHS defined the five core functions of an exchange as: Consumer Assistance, Plan Management, Eligibility, Enrollment, and Financial Management.

There are three options for a Kansas exchange: a state-operated exchange, a federally facilitated exchange (FFE), or the state/federal partnership model. However, the Commissioner stated the possibility for a state-operated exchange would be contingent upon the passage of enabling legislation during the 2012 Legislative Session. It also would be contingent upon obtaining funding for the implementation of an exchange. The deadline for applying to HHS for a Level 1 Establishment Grant is December 30, 2011, and would require a letter of support from the Governor for the grant application. [Since the Commissioner's presentation in November, HHS has extended the Level 1 submission deadline to June 29, 2012.] The Level II Establishment Grant deadline is June 29, 2012, but only is available to states that have enacted exchange enabling legislation. [As of the date of this report, the Level II grant funding deadline has not been extended.] There is no requirement that a Level I grant has been obtained in order to apply for a Level II grant.

The State/Federal Partnership Model would allow a state to take responsibility for the Plan Management function and the in-person assistance to consumers, Navigator management, and outreach and education components of the Consumer Assistance function. All of these functions, as currently defined, already

are performed by the Kansas Insurance Department.

Under an FFE, the federal government would perform all five core functions, including consultation with a state's stakeholders. HHS would make all decisions with regard to those areas where a state would have flexibility under a state-based exchange, and would determine rules for harmonizing the sale of plans inside and outside of the exchange. Finally, HHS would determine the type and amount of user or transaction fees to be used for the ongoing operation of the FFE on behalf of the state.

In August 2011, HHS released statements of work for a federal exchange and data hub IT system. The data hub would verify citizenship, immigration status, and tax information with the Social Security Administration (SSA), Homeland Security, and the Internal Revenue Service (IRS), and would be used to determine eligibility for public programs, tax credits, and subsidies for the purchase of private insurance.

The Commissioner stated Kansas could apply for the Level I grant if the Governor signed the letter. She indicated, if the Governor were to sign a letter for Phase I funding, the Insurance Department would be ready to proceed. She further noted it has always been the intention of the Insurance Department to be prepared to keep as much of the decision-making as possible at the state level. Regarding the cost to the state if the state were unable to get funding and a federal exchange was created, the Commissioner indicated there may be some state cost. The federal government would use the money set aside for a state exchange to develop a federal exchange in the state for the first year of the exchange. After the first year, the exchange would have to be self-sustaining with the use of transaction fees.

In reviewing the status of a health insurance exchange in Kansas, the Committee also heard testimony from Lieutenant Governor Colyer at the September 19 meeting on the return of the Early Innovator Grant by the Governor. He stated that if Kansas had elected to retain the Early Innovator Grant, and thereby adopt the HHS timeline for implementation of an exchange in Kansas, the state would have been forced to begin developing its exchange in compliance with hundreds of pages of regulations, all before knowing whether the United States Supreme Court would uphold the constitutionality of the ACA. Furthermore, because these are only proposed regulations, they are subject to substantial change as a result of the review and comment process, and will likely not become final until mid-2012. The Lieutenant Governor acknowledged that the Brownback administration has a policy wherein there would be no building or implementing of an exchange until the Supreme Court issued its ruling. He also stated that the Legislature needs to have a voice in any decision made.

In summary, the Lieutenant Governor stated that the previous Administration had signed the original grant request, and the current Administration felt it was not the right policy at the present time. Further, should the Supreme Court uphold the constitutionality of the ACA, then the Administration and Legislature would decide which direction to pursue.

The Secretary of the Kansas Department of Health and Environment addressed the Committee on the impact of the return of the Early Innovator Grant and explained that the return of the grant, part of which would have funded K-MED, would not impede eligibility determinations. K-MED would be replaced by KEES. He explained that KEES would be better for Kansans and would determine eligibility quickly for individuals and families, while the current Medicaid eligibility system can take up to 45 days. KEES, in many cases, will allow for immediate determinations. It would be consumer-driven with applicants able to access their applications, renewals, and other information at any time. He also noted that having the information in one place would help policymakers with more complete and accurate

information, and would allow policy changes to be implemented more quickly.

The first users of KEES, according to the KDHE Secretary, would include Medicaid, Children's Health Insurance Program (CHIP), Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance to Needy Families (TANF). The design builds in expandability and would allow Kansas to lead the way in creating efficiencies within Medicaid and across programs. The intention is to have KEES operational by the end of calendar year 2013. In the meantime, eligibility determination would continue using the current process. KDHE projects no backlog with current resources.

The KDHE Secretary explained that funding for KEES comes from a competitive federal grant awarded to the state in 2009, state funds dedicated to this purpose by SRS in fiscal year 2010, and federal matching funds available to states for administering jointly funded programs. KEES implementation does not require Kansas to create an insurance exchange. The 90-10 federal support for KEES originates from an interpretation of Medicaid IT funding rules found in Section 1903(a)(3)(a)(1) of the Social Security Act. The cost breakout is $85 million for technology acquisition and implementation. The contract includes up to $50 million over five years for operations and maintenance.

In addressing funding for KEES, the KDHE Secretary said that federal funding for KEES is neither a grant nor funded under the ACA. The Centers for Medicare and Medicaid Services (CMS) agreed to language in the KEES contract specifically stating federal funding does not obligate Kansas to develop an exchange. Governor Brownback has stated his administration will not move forward to implement an exchange and Kansas remains engaged in litigation challenging the constitutionality of the ACA.

The Secretary of KDHE provided a forecast of the KEES project schedule at the November 15 Committee meeting. The Secretary indicated the project began its detailed planning on August 29, 2011. In 2012, Phase I would include designing, building, piloting, testing and deploying, training, and providing ongoing support. Phase II, the same year, would involve designing, developing, building, and unit testing. In 2013, Phase 2 would continue with integration testing, deploying, and providing ongoing support, with a full KEES system projected for May 1, 2013. Phase 3, with a target date of October 1, 2013, would include additional functionality and ongoing support.

Closure of SRS Community Service Centers

At the September 19 Committee meeting, the SRS Secretary discussed the closing of SRS community service centers. He indicated it was determined that the location and number of SRS community service centers and the regional organization needed review and refinement while making sure SRS became more effective and efficient. That being determined, consultations with regional staff, deputy secretaries, supervisors, and other individuals were held to determine ways to approach reorganization and rationalization of service centers and regional structure. SRS settled on a plan to close nine service centers and merge six administrative regions into four. Agreements to keep SRS offices open by means of those communities contributing to the state's costs of maintaining the offices were reached with Lawrence, Pratt, Fort Scott, McPherson, and Marysville.

The Secretary provided information on the effect the reorganization of community service offices had on clients, staff and on various SRS programs (Children and Family Services, Adult Protective Services, Disability and Behavioral Health Services, and the Vocational Rehabilitation Program). With regard to service to clients, he indicated that the effects of reorganization on Children and Family Services (CFS) and Adult Protective Services (APS) have resulted in creative ways to continue to provide services

with little impact to the clients. Office closings may mean the employees start and end their days in different locations than they did before, but their work remains primarily in the communities and in the homes of the families they serve. The single CFS worker in the Lyndon office has now moved to the Topeka Service Center and will still be assigned intakes from Osage County. Four social workers in the Wellington office were relocated to Winfield, 35 miles east. There has been minimal impact from the Wellington office closing. While social workers may drive approximately 70 more miles when in the field, which was anticipated, SRS currently is utilizing access points and the child welfare community-based services contractor, as needed. There were no CFS workers in the Coffeyville office, so closure of that office had no impact on service delivery. Workers in the Independence and Parsons offices cover all of Montgomery County, including Coffeyville, and Labette County. The single CFS worker in the Garnett office is now working in the Iola office. The CFS unit responsible for Garnett and Anderson County continues to cover that county, as well as Allen, Bourbon, and Linn counties. There has been no change in coverage for Garnett and Anderson County.

The SRS Secretary stated the closure of four SRS offices has had no effect on the programs managed by SRS Disability and Behavioral Health Services (DBHS). Most of the work of the DBHS field staff is done at the providers' sites or with the consumers, wherever they are (homes, work places, or other places). A very limited amount of work is done from the SRS service center offices and much of their work is accomplished via electronic or telephone contact. The single field staff located in the Coffeyville office has transitioned without difficulty to the Independence office and all providers she works with have been given her new contact information.

There was only one Vocational Rehabilitation (VR) counselor affected by the closure in Wellington, and that individual was moved to Winfield in Cowley County. In the case of individuals who cannot travel for required face-to-face meetings, the counselor has the ability to travel to the individual's community to provide necessary services. According to the Secretary, this was already standard practice in the VR Program.

During the November 15 meeting, the SRS Secretary provided the Committee with an update on the closure of several SRS community service centers and discussed the contracts entered into with local government entities to keep their SRS community service centers open. The Secretary stated the SRS budget for FY 2012 forced the Department to find $42 million in savings over the next year. A number of ways to close this gap in the SRS budget were identified, including: delaying computer purchases; eliminating association dues and subscriptions; holding regional office operating expenditures at FY 2011 levels; reducing most grants and contracts by three percent; and eliminating specific grants.

The SRS Secretary stated that the plan also called for reducing the number of SRS service centers from 42 to 33, with a goal to achieve a savings of $800,000 ($400,000 in State General Funds) in FY 2012. Garnett, Lyndon, and Wellington closed September 2, 2011, and Coffeyville closed September 9, 2011. Agreements were reached with five communities (Lawrence, Fort Scott, McPherson, Pratt, and Marysville) in which the local governments agreed to pay the state's costs to keep the offices running. Those expenses to be paid by local governments included rent, utilities, copy machine rentals, and other business costs.

According to the SRS Secretary, SRS intends to ask the Legislature to restore funding for the five community service centers remaining open, because the local communities have agreed to pay the state's cost. That funding request will be in the SRS final FY 2013 budget proposal. There are no anticipated further closings; however, this

may need to be re-evaluated should the budget be cut drastically and the agency forced to find further savings.

At the September 19 meeting, questions arose regarding retirement numbers for SRS. The SRS Secretary stated that 110 individuals (approximately 25 percent), had retired at that time. SRS's intention is to backfill positions, with the priority being to fill hospital vacancies. When asked what SRS's intentions were toward the Kansas Neurological Institute (KNI), Secretary Siedlecki responded that SRS was committed to keeping KNI open.

Newborn Screening and Infant Mortality Rate

At the November 15 Committee meeting, the KDHE Secretary gave a brief history of the Newborn Screening (NBS) program in Kansas. Newborn screening has been part of infant health in Kansas since 1965 when testing for phenylketonuria (PKU) began. Since then, the program has provided additional tests, with the largest expansion beginning in July 2008. Kansas currently screens for 28 inherited disorders. The goal is to identify and treat infants affected by one of these disorders so that disability, mental retardation, or death can be prevented. He noted all of the core metabolic disorders have treatments available. In 2011, 40,697 infants had the initial screening with 2,798 infants having an abnormal screen needing further testing. Decreasing availability of Children's Initiative Funds (CIF) jeopardizes the funding source for the NBS program. The Secretary stated that KDHE is committed to the continuation of this vital service and is working with stakeholders to identify a long-term, sustainable funding source. Funding options include a fee structure, an alternative funding stream, and a combination of the two. He noted that the funds required for Fiscal Year (FY) 2013 for NBS would be $2.8 million.

In response to Committee inquiries, the KDHE Secretary stated, although not on the list of the 28 inherited disorders tested, congenital audiological and visual testing is done; and all tests (blood, hearing, and visual) are mandated in all areas in Kansas. Regarding the Committee inquiry as to the high infant morality rate in Kansas of 9.5 percent, he stated that a Blue Ribbon Panel was implemented two years ago and the rate has decreased. Unfortunately, he noted, there are still significant differences in infant mortality rates between the races, but with earlier access to prenatal care and encouragement to allow more time between pregnancies, the hope is to diminish the differences.

Access to Dental Care

Representatives of the Kansas Association for the Medically Underserved (KAMU) presented the update on safety net clinics and federally qualified health centers at the September 19 meeting. One of the representatives indicated that within their Safety Net System, there are 41 member clinics: 13 are federally qualified health clinics, 20 are primary care clinics (PCCs), and eight are free clinics. Seventeen of these clinics provide dental services with 38 full-time dentists. They are the largest primary health care system in Kansas with 386 full-time providers. Three new clinics are being added with state grant funding.

The other KAMU representative stated Kansas was one of five states to receive a grant from the DentaQuest Foundation to increase the oral health expertise and capacity of Community Health Centers (CHCs) at the national, state, and community levels, so these centers are prepared to care for the growing numbers of people seeking care at health centers. The grant period is from October 1, 2011, to September 30, 2012, in the amount of $100,000. The main purposes of the grant is to improve dental operational efficiencies in CHCs, develop plans to better integrate medical and dental care at CHCs, and increase CHC leadership capacity around oral

health access issues. Kansas is a leader in oral health, as evidenced by the success of a private/public funding initiative aimed at expanding access to dental care in their clinics, known as the Dental Hub Project. Where Dental Hub has built clinics, the DentaQuest project will:

- Build clinic capacity to see additional patients with existing resources through operational efficiencies;
- Focus attention on integrating medical and dental care; and
- Build leadership capacity to further expand oral health programs.

The Clinics' goal is to provide quality care for everyone through increased access, community involvement, and quality care. Fifteen percent of their clients live below the poverty level. In an effort to increase access, due to the number of people served increasing by 30.1 percent, KAMU is working with 14 communities interested in establishing safety net clinics. Two federal "New Access Point" CHC grant applications were awarded in September 2011 for Wichita and Coffeyville clinics.

A KAMU representative noted that safety net clinics are economic drivers and create jobs. Federally funded clinics have a total economic impact of over $81 million, and all safety net clinics directly contribute $85,663,685 to the economy, representing more than a 10:1 return on investment.

KAMU member, Silver City Health Center, was the first practice of any type in Kansas to receive recognition by the National Committee for Quality Assurance (NCQA) as a Patient Centered Medical Home. In addition, 17 members are actively working for NCQA recognition.

At the October 25 Committee meeting, a representative of the Kansas Board of Regents (KBOR) reviewed the Board's recent decision to create a Kansas Board of Regents Oral Health Task Force. She commented on the Board's charge to seek improvements in the delivery of oral health care in Kansas, and she listed the task force members.

The Board of Regents presentation was followed by an update on dental access in Kansas provided by a representative of the Kansas Dental Association (KDA). Referencing the Bureau of Oral Health study "Mapping the Rural Kansas Dental Workforce," the conferee said there are four dental "deserts" in Kansas, and 14 strategically placed dentists could eliminate those voids. To address those and other dental needs, Mr. Robertson said the KDA has outlined several approaches:

- The KDA is working with the Delta Dental Foundation to develop a loan forgiveness program similar to the medical-student loan forgiveness program. Delta is providing a $150,000 start up grant; an additional $50,000 from the state would be helpful;
- The KDA is encouraging dentists to build satellite offices in underserved areas, since a 2009 law now allows a dentist-owner to have a satellite office in counties of less than 10,000 population, without being physically present; this allows an associate dentist to work part-time in a rural office without requiring a supervising dentist;
- One provision of the Health-Care Mega-bill (HB 2182) passed in the 2011 Legislative Session allows dentists to work for hospitals in counties with under 50,000 population;
- The work of the KBOR task force will offer proposals to expand dental services; and
- Wichita State University has completed a residency facility for its new Advanced Education in General Dentistry program, an initiative designed to help retain dentists in Kansas.

The KDA representative said Kansas dentists come from neighboring states; since Kansas has no dental school, the state has a formal arrangement with the University of Missouri-Kansas City to allow in-state tuition for 85 dental students and 12 optometry students in exchange for 491 undergraduate architecture design students to attend the University of Kansas or Kansas State University. He stated the KDA also is providing information to encourage Kansas dentists to participate in Medicaid; during the past year the number of Medicaid patients served increased by 14.2 percent.

Information was provided on two programs to provide dental care to underserved citizens: the Donated Dental Services program, which provides $700,000 in free dental care to the elderly and disabled patients annually; and the Kansas Mission of Mercy Dental Project (KMOM), which has provided 19,000 patients across Kansas with about $10 million of free dental care, to date.

Noting that Medicaid addresses dental care only for children, the KDA representative recommended that the Legislature consider expanding Medicaid for adult dental services.

University of Kansas Schools of Medicine, Smoky Hill Family Residency Program in Salina, and the Medical Student Loan Program

At the October 25 meeting, a representative of the University of Kansas Medical Center and the University of Kansas School of Medicine (KUMC) provided the Committee with an update on the Schools of Medicine in Wichita and Salina and the Smoky Hill Family Medicine Residency Program in Salina. The KUMC School of Medicine is the only medical school in Kansas, and is one of the nation's leading institutions for training primary care and rural physicians. The school has now expanded the Wichita campus and opened a new campus in Salina, enabling the school to reach beyond its previous limit of 175 students: 191 students this year and 211 students in 2012. Further, the Legislature added funds to expand the School of Pharmacy, and private gifts and grants of nearly $5 million have made possible the Salina campus and expansion of the Wichita school. The conferee stated all three schools are connected by interactive television and lectures are podcast as well as video-taped. She noted the Salina campus is the smallest accredited medical education program in the United States (eight students), a fact noted by the national press; it provides a model for other medical schools. The Smoky Hill Family Residency Program in Salina, established by legislative mandate over 30 years ago, has placed 93 percent of its graduates in rural communities and, in the past eight years, has won six awards for excellence in medical education, in addition to receiving various funding grants. Funding for the Smoky Hill residency program comes, in part, from the SGF.

KUMC has added a nursing Ph.D., a Doctor of Nursing, and a Masters program for nurses. The school is developing a medical-home concept, which provides inter-professional medical education through a team approach, a program designed to service larger regions of the state.

A review also was provided on the status of the school's application to the National Cancer Institute (NCI) for recognition as a national cancer center, a project begun in 2005 to recruit scientists, build state-of-the-art laboratory space, and expand research capabilities, and, costing $350 million to date. The conferee listed current accomplishments of the application process: formulation of new cancer drugs, development of personalized cancer treatment regimens, advances in preventive and control therapies, new cancer drug clinical trials, and remote cancer treatments by telemedicine. Gratitude was expressed for the annual $5 million from the State General Fund (SGF), for a $50 million grant from the Kansas Bio-Science Authority, and for the 1/8 cent Johnson County Education

and Research Triangle sales tax dedicated to the Kansas University (KU) Clinical Research Center scheduled to open early next year in Fairway. She also noted the $62 million from hundreds of donors through the KU Endowment Fund, and observed the application process has created 1,123 jobs and has contributed $453 million to the region's economy. The next step is an NCI site visit on February 22, 2012, with a decision on the application by May or June 2012.

If the KUMC achieves the National Cancer Designation, the NCI will provide $1.5 million annually for five years. The school also will be included in a cancer research network and will be able to apply for other grants.

The conferee commented briefly on the student loan program, which provides $2.6 million per year from the SGF. The program pays for a student's tuition and provides a $2,000 stipend; the amount is forgiven if the student graduates and practices in an underserved area of Kansas in the area of primary care. She noted 60 to 70 percent of the graduates stay in rural Kansas beyond the four year requirement. Current tuition for medical students ranges from $35,000 (in-state) to $45,000 (out-of-state) per semester.

According to the conferee, the key to meeting the state's expanded medical needs in the next ten years is the medical-student loan program. KUMC is known nationally for producing excellent primary-care physicians. In considering applications, the medical school places emphasis on those students interested in rural and primary care, and interviews all Kansas students who meet the minimum qualifications. KUMC retains about 48 percent of its students at the Wichita campus and 45 percent from the Kansas City campus to practice in the state. The medical school presently is producing enough graduates to maintain current physician population (it takes 1.3 physicians to replace one retiring physician), but only by increasing the number of students will the school be able to meet the anticipated increase in demand for medical services.

Other areas of focus for KUMC include plans for a new medical education building to replace the present obsolete building, plans to create a school of public health focusing on preventive medicine, and developing individual in-home monitoring services through telemedicine with the anticipation of the Google high-speed internet project in Wyandotte County. Regarding the school of public health, KUMC is working with the KDHE to develop evaluation tools to leverage medical funds more efficiently with the goal of raising health standards state-wide.

Transition of the KHPA into the KDHE Division of Health Care Finance

At the September 19 meeting, the KDHE Secretary provided the Committee with an update on the transition of KHPA duties into the KDHE Division of Health Care Finance (DHCF) pursuant to ERO No. 38. After sharing an updated Organization Chart, the Secretary stated that he felt this was a good health policy and a good budget policy in that there was a combining of a health care finance agency and the agency charged with ensuring public health, including prevention and quality, producing new opportunities for innovation at a critical time—most prominently being Medicaid reform and KEES. Agency-wide planning, including a strategic mapping session in July, brought divisions together to craft and implement a three-year strategic plan. Among eight mission-critical priorities, two were considered cross-cutting throughout the agency: expanding and strengthening key partnerships and using outcomes and measures to continuously assess effectiveness. The three-year strategic plan is a living document that will have received input from all KDHE employees by mid-October.

Examples of opportunities created by consolidation to coordinate increased capacity across divisions cited by the KDHE Secretary were the coordination of Public Health Informatics

and DHCF data analysis functions, along with focusing public health promotion programs to ensure impact on Medicaid populations.

In achieving the agency's time line regarding planning and implementation, the KDHE Secretary noted that, on July 1, 2011, the agency began to function as a fully-integrated unit at the executive management level. He also pointed out they have initiated cross-training of administrative staff to maximize capacity and have established Centers for Disease Control (CDC) funded Office for Effective Performance Management within the Director of Health's Office to maximize collection and utilization of performance measures for the purpose of effecting evidence-based improvements across the Divisions of Public Health and Health Care Finance.

In response to a Committee member inquiry regarding the status of the KHPA Board of Directors, which the member opined had provided independent feedback to the KHPA, the Secretary noted that the Board was dissolved with the reorganization.

A Committee member asked if all positions involved in the restructure were filled. The KDHE Secretary stated that, at the time of his September 19 presentation, there were 35 unfilled positions in KDHE as a direct result of early retirement incentives. KDHE's intent is to fill ten positions at the present time and withhold filling all other openings until KDHE achieves its reorganization goal, and then see what type of funding is available.

Amendment of Health Policy Oversight Authorizing Statute

A revisor from the Office of the Revisor of Statutes brought KSA 2011 Supp. 46-3501, the statute establishing the Joint Committee on Health Policy Oversight, to the attention of the Committee. Under current statutory provisions, the Committee is to "monitor and study the operations of the Kansas Health Policy Authority" (KHPA), in addition to overseeing the implementation and operation of the State Childrens Health Insurance Program (HealthWave). ERO No. 38 abolished the KHPA and placed its duties under the Division of Health Care Finance within the Department of Health and Environment. With this abolishment, the charging statute which sets out the Committee's duties would not be accurate due to its references to the KHPA. It also was noted that the provisions of the statute are set to expire on July 1, 2013.

During the November 15 meeting, the Committee approved a motion to amend KSA 2011 Supp. 46-3501 by replacing the Kansas Health Policy Authority with the Division of Health Care Finance within the Kansas Department of Health and Environment, and to amend the statute to include oversight of general state health care policies. The Committee also approved a motion to change the sunset date to July 1, 2017.

Trailer Bill

During the October 25 meeting, the Committee approved a motion to create a trailer bill to be presented during the 2012 Legislative Session to make statutory changes reflecting the agency change which occurred during the 2011 Legislative Session: the Kansas Health Policy Authority became the Division of Health Care Finance under the Kansas Department of Health and Environment. The motion passed with one member voting no.

At the November 15 meeting, a revisor explained and presented a draft of the trailer bill for ERO No. 38 that was approved for introduction at the October 25, 2011, meeting. The trailer bill makes no policy changes, but only makes needed statutory changes as a result of the passing of ERO No. 38. The revisor indicated the trailer bill would be pre-filed.

Conclusions and Recommendations

Based on the testimony heard and the Committee deliberations, the Committee reached the following conclusions and made the following recommendations:

- Encourage consideration of a close review of managed care contracts, prior to funds being appropriated by the Legislature, to ensure contracts stipulate that no cuts in Medicaid reimbursement rates will be made.
- Recognize the work of the Kansas Insurance Department in continuing the planning process for a health insurance exchange.
- Encourage all state agencies to pursue all available federal funds to assist in the development of a Kansas-run health insurance exchange. (Representative Landwehr and Representative Mast requested their opposition to this recommendation be noted in the Committee Report.)
- The Social and Rehabilitation Services (SRS) Secretary stated he would pursue funding for the SRS offices proposed for closure that remain open as a result of contracts between SRS and local government entities. The Committee would request that a status update be provided by SRS on the pursuit of funding for these offices.
- Encourage the Kansas Department of Health and Environment to consider exploring funding options for the Newborn Screening Program and to consider presenting to the 2012 Legislature any legislation needed to address the funding needs or changes.
- Request that the Committee annually address the issue of infant mortality so as to remain informed with regard to the state's infant mortality rate; obtain data comparing the state's rate with those of other states and the national rate; and consider the nature of the rate as it pertains to factors such as culture, race, and urban and rural populations.
- Encourage further consideration of expansion of the Medicaid program to include adult dental services.
- Consider supporting the Kansas University School of Medicine program's need for a new medical education building to replace the present facility, the plans to create a school of public health focusing on preventative medicine, and the development of individual in-home monitoring services through telemedicine; and to consider funds necessary to accomplish these plans.
- Consider reviewing the medical student loan program for possible incentives to encourage the practice of medicine in underserved areas of the state.

Proposed Legislation

- The Committee recommends legislation be presented during the 2012 Legislative Session to amend the authorizing statute (KSA 2011 Supp. 46-3501) for the Joint Committee Health Policy Oversight by replacing the references to the "Kansas Health Policy Authority" with the "Division of Health Care Finance within the Kansas Department of Health and Environment" and to amend the statute to include oversight of general state health care policies. The Committee also recommends that the sunset date be changed to July 1, 2017.
- The Committee further recommends a trailer bill be presented during the 2012 Legislative Session to make needed statutory changes resulting from Executive Reorganization Order No. 38, which was passed during the 2011 Legislative Session. The trailer bill makes no policy changes and is to accompany legislation to be presented amending the Committee's authorizing statute.