MINUTES

JOINT COMMITTEE ON CHILDREN'S ISSUES

September 28, 2001
Room 514-S—Statehouse

Members Present

Representative Brenda Landwehr, Chair
Senator Sandy Praeger, Vice Chair
Senator Paul Feleciano, Jr.
Senator David D. Jackson
Representative Sue Storm
Representative Dixie Toelkes

Members Absent

Senator Nick Jordan
Senator Janis K. Lee
Representative Gerry Ray
Representative Bob Tomlinson

Staff Present

Emalene Correll, Kansas Legislative Research Department
Hank Avila, Kansas Legislative Research Department
Rae Anne Davis, Kansas Legislative Research Department
Mike Corrigan, Revisor of Statutes Office
Renae Jefferies, Revisor of Statutes Office
Almira Collier, Committee Secretary

The meeting was called to order at 9:20 a.m.

Staff called the Committee's attention to the following materials requested from the Department of Social and Rehabilitation Services at the August meeting:

- Analysis of Expenditures for Foster Care and Adoption: Pre and Post Privatization (Attachment 1);
- Family Preservation Outcomes (Attachment 2);
- Foster Care Privatization Outcomes (Attachment 3);
- Adoption Outcomes (Attachment 4);
- Foster Care/Reintegration Program RFP 00573: Outcome Measures (Attachment 5); and
- Program Instruction Memorandum dated February 20, 2001 regarding Child and Family Well-Being Status Report (Attachment 6).

Attention was called to letters from the Legislative Coordinating Council referring varying foster care and adoption issues to interim legislative committees (Attachment 7).

Staff referred to a copy of the Request for Proposals and contract for year 1 for Region V, noting copies will be provided to any member wishing a copy.

The representative of First Guard, the managed care contractor for HealthWave and as of October 1 for Medicaid children, was unable to be present due to the workload involved in the program change which will combine HealthWave and Medicaid children into one program. The Chair asked that a representative of First Guard be invited to appear at the October Committee meeting as the first conferee on the first day. The agenda for the first day will also include any loose ends that need to be tied up on issues before the Committee today. The rest of the October meeting, the Committee will focus on foster care issues. Staff noted the Kansas Children's Service League recipient of the Robert Wood Johnson grant for follow up on HealthWave was unable to appear because of a scheduled training event.

The Chair referred to the studies the Legislative Coordinating Council suggested the Committee consider (Attachment 7) and, noting the intent to start looking at these issues at the October meeting, asked Committee members to submit any relevant information or specific questions to staff in advance. Questions can then be forwarded to conferees in advance of the meeting.

Committee members who want a copy of the federal audit report were asked to notify staff.

Referring to Attachment 1, staff was asked to find out who is included in "Adult Protective Services Expenditures" and to provide a comparison, if possible, of the figures in Attachment 1 with figures presented to the Ways and Means Committee on September

27, 2001. Other questions relating to the material in Attachments 1 through 6 are to be submitted to staff to be forwarded to the Department of Social and Rehabilitation Services for a response.

Healthwave

Social and Rehabilitation Services. Dr. Robert M. Day, Director of Medical Policy and Medicaid, Health Care Policy Division, of the Department of Social and Rehabilitation Services, presented written testimony, including a chart showing the growth in children's enrollment in HealthWave and Medicaid primarily through outreach programs using the shortened application form (Attachment 8). Dr. Day stated the significant increase between August and September reflects the centralization of enrollment activities in Topeka.

Dr. Day noted that on October 1, 2001, the goal of the Medicaid-Medical Policy team and the intent of the Legislature will be realized with the initiation of a combined HealthWave and Medicaid health insurance program for children that will be referred to as HealthWave. Developing this program to provide coverage for all children in a family will allow the family, if it so chooses, to have one provider for each of the medical services covered. Combining the two has been very complex and has involved considerable negotiation with the Center for Medicare and Medicaid Services (formerly the Health Care Financing Administration). The card for the blended program is very similar to a Blue Cross-Blue Shield card and will indicate whether the client's eligibility is through HealthWave or Medicaid only in the card number. The new application form, available in English and Spanish, is shorter and less intrusive. The goal is eventually to make the form available in other languages. Answering a question, Dr. Day said the data system for the blended program can provide data for Title XIX and Title XXI separately.

In response to a question, Dr. Day stated cases picked up from the federally required review of closed Medicaid cases shows up in caseload projections rather than in the chart attached to the testimony. He emphasized the chart shows the number of children moving into the blended program through the centralized clearing house, not the total number of children enrolled.

Dr. Day continued by emphasizing the purpose of the blended program is to provide a better product for consumers by blending the Title XIX and Title XXI programs into what can be a coverage plan for all eligible children in a family. One problem encountered was the legislative mandate that all Title XXI services be provided in a capitated format, coupled with the fact that Kansas had the lowest reimbursement rates of any state having capitated managed care. Kansas has increased the managed care rate by 32 percent without having to raise fee-for-service rates since managed care rates are, by federal mandate, built on a fee-for-service schedule. The 32 percent increase does not take into account increases in managed care rates in other states or in general. Kansas capitated rates for managed care entities will be low as long as physicians are underpaid since, by federal mandate, rates must be based on historic fee-for-service models trended forward.

Data show beneficiaries tend to move between programs or drop out of a program prior to the twelfth month of continuous eligibility. This is due largely to inadvertent actions in the current welfare eligibility system. In very few cases is it due to nonpayment of premiums. The problem is being addressed in several ways. One is by changing and

increasing outreach efforts. The contract with Maximus now covers only awareness activities such as billboards, radio spots, television spots in both English and Spanish, and theater trailers. To help local communities assume ownership and responsibility for outreach, other outreach programs have been moved from the central office in Topeka to the area offices. Through the area offices, grants totaling $250,000 are being given to local entities who work with the targeted populations. Data will be gathered to determine the success of all outreach programs. The other step is "delinking," or assigning a case number to the eligibility files for HealthWave and Medicaid that is different from the case number for other benefit programs. Although it will take 12 months to phase in delinking, there should be some indication of the success of this effort in six months.

The conferee stated in Medicaid enrollment approximately 80 percent of eligible beneficiaries make no decision when asked to select either a managed care product or Health Connect, a primary care case management program. To address this, a computer logic program has been developed which searches the claims history of each applicant to determine if there is a selected primary care physician and, if there is, whether or not the physician is in the HealthWave or Health Connect network. The computer program also scans each application to see if there is a child eligible for Title XXI. If there is, the computer logic defaults the family into a managed care product giving the family a single health care provider. The family then has 90 days to decide whether or not to be in managed care. It is important to have a system that constantly looks at what will be the best coverage for the beneficiary.

In answer to a question, Dr. Day said it is difficult to know exactly how many uninsured children there are in Kansas who would be eligible for HealthWave or Medicaid. The original Consumer Product Survey estimate of 60,000 was based on a very small nationwide sample of 500 households and would appear to be unreliable based on a cursory look at the preliminary data from the Health Resources and Services Administration study based on 8,000 households. By the 2002 Legislative Session, more accurate information, including where eligible uninsured children are located, should be available. Responding to further questions, the conferee said that close to 60,000 children have been enrolled either in Title XIX or Title XXI. All the federal money Kansas received will be used. During the last two years, the federal allocation to states decreased so most of the money Kansas would have had to return has come back to Kansas. Asked about dental coverage, the conferee said the Title XXI program requires a dentist be in the Doral network since it is a capitated plan. In Title XIX, the dentist does not have to be in the Doral network, but Doral will assist a recipient in finding a dentist. Speaking to a statement expressing concern that Doral had been awarded the dental contract after the dental group had registered dissatisfaction with Doral's services, Dr. Day pointed out Doral's previous contract, which was under-financed and included only a small number of children, was with Family Health Partners, not the State of Kansas. Doral agreed the concerns of the dental group were legitimate and would be taken into consideration in the new bid. Doral's bid met all the criteria of the Request for Proposals, included some data functions such as utilization data not included in any other bid, and was substantially lower but comparable with what the state was paying Delta. Also, Doral now has a presence in Kansas. Contracts can be renegotiated if both parties agree to renegotiate.

Responding to a question, Dr. Day stated getting adequate and appropriately placed networks of providers is a problem. Kansas has a sufficient number of physicians, but there is a reluctance to be part of a capitated managed care program due to the low reimburse-

ment rates, especially for primary care physicians. Kansas rates are below the physician's actual cost in some cases. Although there was a net gain of 200 physicians last year, the more crucial issue is how many Medicaid patients each physician will take. A physician must balance the number of Medicaid patients with a break-even rate of reimbursement or even reimbursement that is below the break-even point against the number of commercial or cash patients. The Department of Social and Rehabilitation Services and the Kansas Medical Society are working together to envision what should be done to provide a competitive environment that will attract physicians into the system, to prevent those in the system from leaving, and to determine the effect of rate increases. A number one priority for the Medical Policy Section of the Department is a rate enhancement request to stabilize the current program. On the dental side, a primary concern is the shortage of dentists, coupled with the prediction of fewer dentists serving more people. Dentists' rates, although still low, are 90 percent of the average commercial rate, which puts dentists in a better financial situation than physicians.

In answer to a question, Dr. Day stated carving dental care out of managed care was a decision made by the state agency and was based on the fact the managed care plans did not want to continue including it. Health plans basically treated dental services as a pass-through and were not equipped to negotiate rates or manage dental services. The possibility of deleting pharmacy services from the managed care contract once the new Medicaid information system is in place is being explored since bids, to a great extent, are built around assumed risks for pharmacy costs. While dental and mental health services have been carved out of managed care contracts, managed care providers are still responsible for drug costs that may be incurred as a part of dental or mental health services. However, the payment rate for the health plans has taken into account historical data on mental health drugs for this population and has trended it forward.

The conferee, responding to a question, noted under HealthWave only community mental health centers can provide mental health services for children since the Consortium network is owned by and includes only the centers. Substance abuse cases, which make up a very small number of the total cases, are not considered a health problem by Medicaid except for hospitalization. These cases may be referred to another agency. Access standards are built into the mental health contract, and quarterly reports for each mental health center are required. The issue of foster care children's access to mental health services is between the contractor and the specific mental health center. Access through the Consortium is being addressed in a proposed amendment to the contract with the Consortium. The issue of the implications and problems posed because of the mental health monopoly created in Kansas was raised. The Chair asked that anyone interested in looking at ways to address these implications and problems and look for solutions, contact her.

Dr. Day was asked to provide information on the areas that have an inadequate number of providers, a side-by-side comparison of services that HealthWave, Medicaid, and the new blended system provide, and a copy of the access standards included in the mental health contract.

Kansas Health Institute. Andy Allison, economist and a research staff member, Kansas Health Institute, said the vision of the Institute, a nonprofit and nonpartisan organization, is healthier Kansans through informed decisions. The Institute was started in 1998 with a long-term grant from the Kansas Health Foundation and receives no money

from the state. The project being reported by Dr. Allison is funded by federal grants, with additional monies from the Kansas Health Foundation and United Health Ministries Foundation.

Dr. Allison presented an outline of the testimony (Attachment 9), including background information on HealthWave, policy questions being addressed in the research project, data and methods used, charts showing the findings to date, a summary, and important implications of the findings. Dr. Allison stated data, going back to the middle of 1998 with monthly updates, used in the project comes from the subcontractors for the Department of Social and Rehabilitation Services and official enrollment records for HealthWave and Medicaid. The Institute is in the midst of a three-year evaluation of HealthWave. Surveys of enrollees are being conducted, and a survey of those not re-enrolling will be done in the coming months. Most of the analysis should be completed by October 1, 2002. The findings presented include data through May or June of 2001. In response to a question, Dr. Allison stated data after the implementation of the blended program can be compared to earlier data because the new ID number indicates whether the enrollee is under Title XIX or Title XXI.

As of May, there has been an increase of over 50,000 children covered or over a 50 percent increase. Approximately 15 percent of the children are covered by HealthWave. If the present trend should continue, which may or may not happen, there would be a total increase of 71,000 children. One of the surprising aspects of enrollment over the last two years is that enrollment increases have not decreased as one would expect with the maturation of HealthWave. After 27 to 30 months, almost constant increases are being seen in the two programs combined.

In answer to a question, Dr. Day reiterated the chart he presented shows the effects of the short application, centralized enrollment process, and outreach activities. It encompasses only those children enrolled through the clearing house in Topeka. Many of the children in Medicaid enroll through the local Social and Rehabilitation Services offices. Dr. Allison stated the Institute's numbers include people actually being brought into the health insurance program through outreach activities and the short application form.

Dr. Allison stated the number of children entering HealthWave and Medicaid exceeds the number exiting the programs only slightly. This probably indicates that to reach the goal of increasing the number of children covered will require as much focus on retaining children in the program as on getting new enrollees.

Dr. Day, in response to a question, noted Kansas law states there will be 12 months of continuous eligibility. The only reason for ineligibility would be that the child aged out of the program. A survey of a random sample of people who left the program indicated a contributing factor was "preventable administrative action." For example, a family enrolled in HealthWave who later enrolls in the food stamp program should remain in HealthWave. However, the automated system, based on the application for food stamps, would automatically put them in Medicaid. To keep the family in HealthWave requires a manual override which does not always happen. This problem is being addressed by the delinking discussed earlier.

A Committee member asked that the record reflect Dr. Day told the Committee that a change in income during the year, *i.e.*, enrolling in the temporary assistance to families or

the food stamp program, would not result in a child being removed from the HealthWave program until the child had completed one year of coverage. Dr. Day reiterated that this is the goal of delinking. He stated if a family in HealthWave becomes eligible for Medicaid, the family can be moved to Medicaid in the blended program without affecting coverage. The family may keep the same provider and stay in the same network. Currently, the Department is working on giving the family an option if this occurs.

Dr. Allison, referring to the chart entitled, “Figure 2: Monthly Probabilities of Survival in ‘New’ SCHIP Spells Conditional on Enrollment Until Month 4" (Attachment 9, Page 9), a comparison of Title XXI children in four states, including Kansas, is an unpublished chart for an academic journal article. These states have projects funded by the same federal agency that is funding the project in Kansas. Approximately one-third of the children leave the program at some point during the first year. About one-half of those still in the program at the end of 12 months do not re-enroll. Only about one-third of the children remain in the program 13 months after enrolling. A child transferring to Medicaid shows up as an exit in this chart. Approximately 37 percent of children leaving HealthWave transfer directly into Medicaid. The chart shows only those children continuously enrolled in HealthWave. If children who leave the program for a month or two, called slow enrollers, are added back in, there would be an uptake in months 13 through 15.

A question was raised as to whether or not the education piece of the program is being implemented and how effective is it. Dr. Allison stated it is hoped the survey of children who do not re-enroll after a year in the program will provide some answers to questions such as: What did they know about the re-enrollment process? What information were they given? Were they confused about the process?

After a discussion of the chart, staff was asked to get information on the Florida program, including whether the program is based on a fee-for-service or capitated rate, what type of audit is done to assure only those eligible are enrolled in the program, and the cost of the audit.

Referring to the next charts, Dr. Allison stated, based on data starting mid 1998, approximately three-fourths of new enrollees in HealthWave had been enrolled previously in Medicaid. About a third of the children leaving HealthWave transferred directly into Medicaid with no break in coverage. As the child ages, the income threshold for Medicaid falls, resulting in approximately one-fourth of the families having a child in HealthWave and Medicaid simultaneously. Nearly two-thirds of the children in HealthWave are at risk for moving back and forth between programs or being in a family with dual coverage. The new blended program should eliminate some of the movement between programs and the dual coverage. A question was raised as to the possibility of determining the distinctions between children accessing health care for the first time and those who had access previously. What impact does the fact that approximately three-fourths of the children covered in HealthWave were previously covered in Medicaid have on the anticipated level of unidentified health problems? It was suggested the Kansas Hospital Association be asked to pick a few hospitals randomly to see what data is available on children without insurance who appear in the emergency room. Dr. Day offered to follow through on this suggestion.

Kansas Medical Society. Jerry Slaughter, Kansas Medical Society, stated a statewide network of physicians, as well as of other providers, is necessary for the success of the Title XIX and Title XXI programs. The Kansas Medical Society believes that caring

for the indigent is a shared responsibility between the provider community and the state. Success requires a partnership. Kansas now has a stable program, which, at least at the plan level, is adequately funded. Providing an enrollee card that looks like a Blue Cross-Blue Shield card is a step toward destigmatization. However, there is a very real potential for a deterioration of the physician network that supports these programs. Providers do not expect participation in these programs to be profitable. However, a fee schedule developed in 1976 with a few fixes for specific specialties, coupled with increased insurance premiums and what is happening in the commercial market, are making it more difficult for physicians to include more patients from these programs. It takes 55 to 60 cents of each dollar to run a practice. Yet a physician receives only 20 to 30 cents on each dollar for Medicaid patients. An earlier study showed the Kansas fee schedule was last of the 42 states surveyed. A study done two and a half years ago showed Kansas below the states in our peer group. The physician community does not feel the state has to solve the fee schedule immediately. However, it would send a tremendous message of good faith if the Legislature would express the realization that the network providers have taken some financial hits and, although the problem cannot be solved immediately, enhancements can be phased in over time. The Kansas Medical Society has engaged an actuary to provide creditable numbers and will be meeting with Dr. Day and other state staff to present what the Society feels it would take to maintain an adequate network of physicians. It will be an incremental approach. First Guard has expressed support for enhancements and a desire to make sure any enhancements the Legislature makes will get to the providers. A task force is working on developing a proposal and, hopefully, information will be available in 40 days.

Responding to a question, Mr. Slaughter stated two approaches are being considered. What it would take to totally revise the fee schedule, including updating the underlying methodology for setting the fee schedule to provide a scientific basis for keeping it current. Then look at targeting some specific services, *i.e.*, primary care, extensive care for babies, and some basic surgical services. One idea the task force is considering would be to tie the fee schedule to the Medicare fee schedule, using the formula Congress uses for annual adjustments with a 2 percent annual increase maximum. The second approach being considered is to modify the fee schedule in increments over time. Mr. Slaughter stated providing an adequate network of physicians is a priority of the Kansas Medical Society. Since the implementation of HealthWave, the number of physicians participating in the program has increased by 300. There is a willing provider community that is asking the Legislature to address the inadequacy of the current fee schedule in an incremental way.

Maximus. Theresa Koehler, Project Manager for the Kansas HealthWave Project at Maximus, provided a bullet outline of the information to be presented (Attachment 10) and the brochure and application for child health insurance (Attachment 11). Ms. Koehler stated in August, Maximus completed the third year of the contract with Kansas. The numbers given on page 1 of Attachment 10 relate to the number of actual children eligible and covered. Under this contract, Maximus continues to do marketing activities of an informational and promotional nature and works with the outreach coordinators in each region to support community outreach activities with appropriate marketing activities. The person-to-person activities have been shifted to the communities. Assistance was given the state in designing the consolidated application for the blended program. Maximus also supports a toll-free customer number including assistance in completing the application over the phone. When an application is received, Maximus does a review to determine who within the family meets Title XIX or Title XXI criteria as a funding stream for health care. Very few verifications of information are needed since most information can be accepted on

the declaration of the family. A decision on the application must be made within 20 days of receipt of the application, although a more expedited process is required for certain categories of applicants, *i.e.,* for pregnant women a decision must be made within 10 days of receipt.

Ms. Koehler noted on July 1, the state began its efforts to centralize and blend the Title XIX and Title XXI programs, which included starting the transfer of cases from all over the state into the clearing house in Topeka. The goal is that within one year, children receiving any kind of medical assistance that is not tied to disability, will be cleared through the clearing house. Maximus has been asked to be the enrollment broker for the blended program and began implementing services on August 15. Services through the toll-free number include assistance in such matters as finding a doctor or changing doctors and in registering grievances. Grievance calls are recorded and a hard copy is faxed to Social and Rehabilitation Services the same day, giving the state the potential of intervening on the same day. Enrollment packets and provider directories are also sent out in response to requests received on the toll free phone service.

Speaking to the delinking aspect of the blended program, Ms. Koehler stated if a family is receiving Temporary Assistance to Families through a local Social and Rehabilitation Services office, the clearing house Maximus manages would carry the medical component under a separate case number. This system maintains the ability to do an inquiry on an individual to see the history and array of services being received.

In response to a question, Ms. Koehler stated Maximus has staff members who are bilingual in Spanish and English. People who are bilingual in other languages are being recruited. Currently, if a caller needs another language, staff can connect them through a conference call with an appropriate person through the telephone company's language line. Berlitz has been asked to give a quote on translating the application form, which would be available electronically, into 12 other languages.

Staff, noting HealthWave is listed under health plans in the Topeka phone directory yellow pages, was asked to see if phone directories in other cities carry this listing.

Kansas Health Insurance Study

Dr. Barbara Langner, University of Kansas, and staff for the *Kansas Health Insurance Study* conducted for the Kansas Insurance Department provided an outline of the testimony and charts showing the findings to date (Attachment 12). Dr. Langner stated the Insurance Department received a $1.3 million grant to gather data about the uninsured in Kansas to be used as a basis for developing a plan to provide coverage to the uninsured. A steering committee having broad representation was named to assist with the project. The first piece of the study was a large household telephone survey with a target of 8,000 interviews. The state was divided into ten regions, based on demographics and employer characteristics. The study was over-sampled for groups typically associated with under-insured status. The interviews were supplemented by a qualitative study to enrich and understand the data secured through the telephone interviews. A Massachusetts firm was hired to hold focus groups with small employers, insurers, and brokers. The Insurance Department contracted with the University of Florida, which had conducted telephone surveys in Indiana and Florida, to conduct the telephone interviews. The interviews, conducted from March to June,

2001, included 8,004 households. The interviewer asked that the respondent be the person most knowledgeable about the health and insurance status of members of the household. A series of questions was asked about all members of the household, with more questions being asked about the respondent and one representative child. Interviews were conducted in Spanish and English. Estimates hold up at the 95 percent confidence interval of plus or minus .3 percent statewide.

Some of the findings are:

- Overall, Kansas has less uninsured than the Consumer Product Survey would suggest by approximately 244,000 persons.
- There is a lot of variance between the ten regions.
- Lower income people are more likely to be uninsured.
- Children have lower rates of being uninsured because of the Medicaid and SCHIP expansion.
- The problem age is 19 to 24.
- An individual is more likely to be insured if working for one employer full time.
- Kansas appears to have two groups of uninsured, the transitory uninsured who typically get insurance within a one-year period and a substantial number who have never had insurance or have been without insurance for a very long time.
- Of the uninsured, 56.3 percent cite cost as the primary factor.
- The majority of children are covered through employment-based plans, although a number of children are covered in the individual market. The latter figure is important given the precariousness of the individual market.
- Approximately 15 percent of Kansas children are enrolled in Medicaid.
- About 46 percent of the uninsured do not have insurance available.
- Employer-based insurance varies significantly across the state.

Dr. Langner noted the last charts relate to whether or not insurance matters in terms of getting health care, with the general finding that it does matter for both children and adults. Children appear to get into the health care system better than adults. If there is a medical home, persons are more likely to receive health promotion, disease prevention, and early intervention. The source of care varies for the insured and the uninsured. More children without insurance use clinic settings. Uninsured children do not go to the doctor as often. Not surprisingly, persons without insurance pay more out-of-pocket because they do not have a discounted arrangement.

In response to questions, Dr. Langner stated uninsured was defined as uninsured at the point in time the question was asked. However, subsequent questions related to how long the person had been uninsured. Interviewers did not concentrate on one region at a time. Samples were released only when every region was up to a certain number of calls. She noted the Insurance Department has just started receiving the raw data from the University of Florida. The raw data will allow the Department to make additional analysis as appropriate. Committee members were asked to give specific questions to Emalene Correll. Dr. Langner will try to respond to the questions as the raw data is analyzed.

Doral Dental. Gary Mandernach, Doral Dental, introduced Raymond Peters, Panel Director, who works with the dentists in the state. Mr. Mandernach stated Doral, currently in 26 states, is a privately held company formed in 1993 by people who are taking technology into the medical assistance community and helping states to increase utilization for children. The companies use of software applications is helping increase access for children and reducing costs for the governmental entities contracting with Doral. Based on a study comparing 1998 information from 48 states to 2000 information, the Health Care Financing Administration determined that increasing access should be a main goal. Four guidelines to improve access were developed for emphasis by the states.

The first guideline is to inform Medicaid beneficiaries about eligibility for dental services and facilitate referrals to dental providers. Kansas is providing a brochure about the benefits and is asking the primary care providers to inform patients of the dental benefits available. Doral has helped develop the member handbook for Kansas which has been mailed out to members.

The second federal guideline is paying adequate rates for dental services. Health care providers are concerned about the inadequacy of fee schedules, but Doral does not believe this is the total issue. Other issues are the shortage of dentists and the fact dentists have all the patients they want. Mr. Mandernach noted the rate for dentists in Kansas is higher than the rate in Missouri. Doral formed an advisory board and, based on information Doral had and information from a Kansas Dental Association survey, has made recommendations to the state.

The third guideline is to employ administrative strategies to enhance participation. Doral, believing the Kansas Dental Association should be a part of the partnership with the state, has developed a working relationship with the Association. There is an article in the Association's newsletter about Doral's "Take Two, "(take two families) program. One person has been asked to be Doral's spokes-person to dentists to encourage participation.

The fourth guideline is to improve claim processing. Doral is using technology to streamline submission of claims and to process claims. Dentists will be provided software free of charge so claims can be submitted via the Internet and, in some instances, the dental office will be given a computer. Information is downloaded daily, and payments are made twice a month. Doral hopes to be able to start providing pertinent data relative to access, utilization, and services delivered, as required in the contract, within 90 days.

Mr. Mandernach was asked to provide staff with a copy of the complete Health Care Financing Administration report from which the four points were taken.

Mr. Mandernach stated 211 dentists, approximately 30 more than last year, have signed up with the program. Responding to a question, he stated some participating dentists will provide services only for existing patients. Doral would like for all dentists to participate by taking at least two new patients and to move up from existing patients only, to accepting all new patients. Mr. Mandernach was asked to send the Committee a map showing where the dentists participating in the program are located. Further responding to questions, the conferee said Doral pays the dentist a fee for service. Providers are guaranteed fees, based on the minimum of the Medicaid fee schedule. HealthWave providers are paid the same rate as Medicaid. Doral provides only administrative services for the Medicaid program. The number of visits per child depends on the number of visits it takes to provide the benefits covered by the program. There are approximately 22,000 children in the SCHIP program. The conferee indicated he had not seen figures for Title XIX. More dentists are needed if all eligible children are to be seen. As access increases, as required in the contract, the number of participating dentists becomes even more crucial. Since the contract started July 1, 2001, and there can be a claim lag of 180 days, sufficient access data is not yet available on the number of children being seen, but data will be provided in December. Mr. Mandernach was asked to provide this information during the 2002 Session.

Dr. Day noted the contract with Doral includes an access rate. A specified percent of children above the current percent in the Medicaid program have to be seen. Hopefully, utilization will increase since dental services are listed on the back of the enrollee's card. There is an individual cap of $1,500 per year for a child. The state pays for anything beyond that which meets the medical necessity criteria, except in the SCHIP program. The contract sets administrative services at 12.5 percent.

Noting that previously other providers had been asked to educate patients about the need for and importance of dental services, a question was raised as to whether or not separating out dental services might impact negatively on this source for educating patients.

Kevin Robertson, Kansas Dental Association, responding to a question, stated there are 1,150 licensed dentists currently practicing in Kansas.

Mr. Mandernach noted Doral's software allows for quicker detection of discrepancies in services being billed. For example, a dentist was seeing children for the first time for diagnostic services without taking X-rays. This was detected within 30 days, and a dentist and a Doral representative met with the dentist to correct the problem.

Child Care Rules and Regulations

Chris Ross-Baze, Director of the Child Care Licensing and Registration Program, Kansas Department of Health and Environment, presented a packet of material, including written testimony on the content and status of the development of regulations specific to after-school child care (Attachment 13) and two child care statutes, KSA 65-501 and KSA 65-525, amended by the Legislature last session (Attachment 14). Ms. Ross-Baze noted KSA 65-501 was amended to update language and exempt certain summer instructional camps from regulation. The exemption applies to camps serving children 10 or older, of not more than five weeks in duration, and accredited. KSA 65-525 was amended to further clarify what maternity center, child care facility, and family day care home information can

or cannot be released to the public. Ms. Ross-Baze reviewed these clarifications as presented in the written testimony.

Referring to the current status of school-age program regulations, Ms. Ross-Baze stated Health and Environment, with the involvement of state and community partners, has drafted a proposed definition for the regulation of school age programs and proposed licensing regulations that are currently being reviewed by the Attorney General's Office and the Department of Administration. It is hoped the review process can be completed and the regulations adopted before the spring of 2002. The intent of the Task Force noted below was to develop regulations that made sense in relation to the programs being regulated. Serious attention was also given to the financial impact of the proposed regulations.

Ms. Ross-Baze stated Secretary Graeber invited 251 persons (stakeholders) to be members of a School Age Regulation Task Force (Attachment 15). Two rounds of meetings were held at six locations around the state. The purpose of the first round was to build consensus on certain issues and the second provided an opportunity for Task Force members to advise and comment on a draft set of school age regulations. The final product, the proposed regulations currently under review, is a consensus of recommendations and comments made by stakeholders and community partners. A copy of proposed definitions, the regulation specifying which programs are required to be licensed and which are exempt, and the table of contents for school age program regulations showing all the areas being looked at in the regulations (Attachment 16) was distributed to the Committee. Ms. Ross-Baze then reviewed which programs will be required to be licensed and the programs that are exempt, giving examples of each. Out of the 22 school age programs in Wyandotte County that inquired about licensure last spring and summer, 11 would not require licensure. Of the 11 requiring licensure, seven received a temporary permit or license, two applications are pending, and two programs, not currently operating, did not apply.

Responding to a question, Ms. Ross-Baze stated there is still a 35-foot per child requirement for licensure, but it is being applied much differently. Rather than applying to each room, it is now applied to the total space used by the children. There is also some flexibility depending on the activity taking place in the room. Outdoor space is not required, but if there are outdoor activities, the 75-square-foot requirement applies only to the children on the playground at one time. Because of concerns expressed about the age restrictions for volunteers, Ms. Ross-Baze stated she would check this section of the regulations. The intent of the regulation was that the person be 16 or at least two years older than the oldest child in the group the person is responsible for. Because of issues raised concerning licensing of boys and girls clubs, Ms. Ross-Baze volunteered to check on which boys and girls clubs are currently licensed.

In response to comments, Ms. Ross-Baze stated there are two kinds of after-school programs provided by schools that have come to the Department's attention. One is the extraordinary school day tied to people outcomes seen during the academic day. These are not licensed. The other is child care programs being operated by the school which are required by statute to be licensed. It was noted Kansas law prohibits anyone who has been convicted of certain crimes to participate in any way in child care facilities, even as a volunteer. In discussions during the last legislative session, the issue was raised about some circumstances in which it might be useful and perhaps helpful to have people who have been through the judicial system work with kids, at least as a volunteer. Yet the law is absolute except for those whose record has been expunged. Ms. Ross-Baze stated

discussions in the Task Force meetings related only to an individual or panel being brought in a few times a year. A person is considered a volunteer based on what he does and if the program defines him as a volunteer.

Ken Davis, Director of the School of Allied Health, University of Kansas Medical Center, stated he became involved as a consultant to United Way of Wyandotte County on issues dating back to a year ago last summer when summer youth programs were initiated through funding from America's Promise and the Juvenile Justice Authority made available to churches and other organizations in Wyandotte County. Suddenly some of the programs were apprised of the fact they came under the constraints of child care licensing. They had not been aware they needed to be licensed. Some programs that had been ongoing for some time were notified they were in violation of the law. A coalition was put together, including Youth Opportunities Unlimited, United Way of Wyandotte County, the Wyandotte Interfaith Sponsoring Council, and others involved in child care programming to deal with this issue. Learning that Health and Environment was considering changes in the regulations pertaining to school age programs, many coalition members participated in the Task Force meetings. Many of the individuals involved participated in the workshops on the regulatory changes.

Last fall Social and Rehabilitation Services, using funds remaining in a federal grant and the Kaufman Foundation, gave the United Way of Wyandotte County approximately $170,000 to be used for mini-grants to various organizations east of Highway 635 that were trying to become licensed or to improve their licensing condition. Moneys for some $3,000 in supplemental grants also became available. All 11 grant applicants received grants ranging from $5,000 to $18,000. As a result of the grants, four or five programs not able to meet licensing criteria have been able to be licensed.

Mr. Davis stated the coalition feels the state agency has responded satisfactorily to its concerns and is satisfied with the process followed to make changes in the regulations. There is some concern over requiring programs operating more than 12 hours a week, a compromise threshold, to be licensed since after school programs in Wyandotte County usually operate for 16 hours. One member of the Committee noted the 12-hour threshold may be too low to respond to the concerns of some programs. For example, a program operating three hours a day, five days a week would exceed the threshold. Another member expressed concern that a program serving 100 children, but operating for only 10 hours a week, would not be governed by any regulatory process. Ms. Ross-Baze, answering a question, confirmed there is no other type of regulatory process applicable to such programs. However, cities do have fire codes that would be applicable. She noted the 12-hour trigger was a compromise reached after a great deal of discussion. She also noted there will be public hearings at which the threshold and any other issues relating to the proposed regulations can be addressed.

Transitioning from Foster Care

Jennifer Propp, Assistant Director of Child Welfare, Department of Social and Rehabilitation Services, presented written testimony (Attachment 17). Ms. Propp stated the primary goal for each child placed in state custody is to reintegrate the child into the family home. If this is not possible other goals such as adoption or permanent guardianship are considered. When none of these goals is achievable, the child remains in foster care until

he or she reaches majority, with a case plan goal of self-sufficiency. During FY 2001, 144 youth transitioned out of foster care due to age.

According to the conferee, Social and Rehabilitation Services is responsible for assuring children in foster care age 16 or older receive independent living services regardless of the case plan goal. The John J. Chaffee Act of 1999, (see Attachment 17) has sparked a renewed emphasis on understanding and better serving this group of young people who have been overlooked and ill prepared for the transition from foster care to self-sufficiency. Recently, Kansas has undertaken an overhaul of the independent living program to assure that services are delivered and are appropriate and comprehensive. Last year in Kansas, 200 of the 1,912 youth ages 16 to 18 in custody had a case plan goal of self-sufficiency because no other permanency plan was appropriate for them. The remaining 1,712 youth received, and may still be receiving, independent living services. Foster care contractors are responsible for providing independent living services and programming. The challenge in providing services is the connection between classroom learning and daily life and finding the balance between teaching tangible versus intangible skills. Generally, youth in independent living situations move into apartment settings and receive supportive services through community mentors, case managers, drop-in centers, and peer groups. Usually youth are not allowed to move into a separate living situation until they have received a high school diploma or GED and are holding a steady job.

Ms. Propp stated once youth exit the Kansas foster care system, there is no formal tracking of outcomes due to the cost and time involved in doing ongoing longitudinal studies. There is also the delicate balance between the desire for data to improve the child welfare system and the youth's need for privacy and a sense of moving on in life. However, Health Care Policy within the Department is beginning to look at administrative data matching, hoping to find ways to access some data. The few national outcome studies available have found disturbing results for youth who have left the foster care system and made the transition to adulthood. In Kansas, 1,001 of the 1,912 youth ages 16 to 18 currently in foster care have received a high school diploma or GED, 905 are enrolled in secondary education, 1,010 are employed, and 141 are reported to be attending college. However, as national outcome studies indicate, these youth may not always be able to function well once they transition out of foster care.

Responding to a question, Ms. Propp stated some evaluation is done. A transition to adult life checklist to see how well prepared a youth is to make the transition is used at the beginning of the training process and at the end. Under the Chaffee Act, a tracking system and outcome measures are being developed that should be in place next year. Currently, there is a pilot project in three states. State participation will be a federal mandate. Originally a three to five-year follow up was included in the federal legislation, but that was dropped because of privacy issues and the difficulty involved in tracking the individuals.

Ms. Propp was asked to provide the Committee with data indicating how long the 144 youth who aged out in 2001 had been in the system. In answer to a question, she stated the availability of independent living services varies across the state. Some contractors manage and maintain scattered site apartments. The need to get information relating to what the various contractors provide and are doing for these youth was noted. Responding to a request, Ms. Propp stated a breakout by regions of the 1,912 youth noted on page 4 of Attachment 17 could be provided.

In answer to a question it was noted that, of the Chaffee dollars coming to Kansas as of 2001, $37,000 is available for assistance and direct services for older youths who have left foster care. Ms. Propp was asked to find out how many youth are receiving this assistance. Ms. Propp was also asked to provide a breakdown of all funds, including State General Funds, being used on the program one year prior to the new foster care program, 1996, and for each year up to the current year for the next meeting of the Committee.

Responding to a question, Ms. Propp stated it is an expectation that contractors will provide independent living skills programs, but there are no incentives such as an enhanced rate to do so.

It was suggested providing some financial incentives might be considered. Staff noted a woman who had aged out of foster care stated the most valuable resource for her was a continuing relationship with her foster care parents. This may be an asset contractors have overlooked. Ms. Propp noted that an advisory council has been created of youth who are currently in foster care and who have aged out. This group has been a wonderful resource as the agency looks at possible changes in the program.

October Meeting

The Chair stated the first item on the agenda for the October meeting will be "loose ends," including HealthWave and any others the Committee feels should be addressed. The rest of the meeting will be devoted to foster care. Committee members are to let staff know of any specific people they wish to have invited as conferees. Staff was asked to invite Joyce Allegrucci, Secretary Schalansky, St. Francis, and the other contractors. Questions for Dr. Langner are to be sent to staff who will forward them. Staff was asked to get an answer from Doral as to how they could spot the X-ray issue in 30 days, but not be able to provide information on the number of children dentists are seeing and other information because they are waiting for the billing process. The Committee requested that Doral be asked to provide specific information on the number of children eligible for dental services and the number of children dentists have taken or will take. Other questions for Doral are to be sent to staff to forward for answers.

The meeting was adjourned.

Prepared by Almira Collier
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Approved by Committee on:

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