MINUTES

JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT

September 19, 2011
Room 548-S—Statehouse

Members Present

Senator Vicki Schmidt, Chairperson
Representative Brenda Landwehr, Vice-chairperson
Senator Pete Brungardt
Senator David Haley
Senator Laura Kelly
Senator Roger Reitz
Senator Ruth Teichman
Representative Don Hill
Representative Peggy Mast
Representative Susan Mosier
Representative Louis Ruiz
Representative Jim Ward

Staff Present

Iraida Orr, Kansas Legislative Research Department
Melissa Calderwood, Kansas Legislative Research Department
Amy Deckard, Kansas Legislative Research Department
Jay Hall, Kansas Legislative Research Department
Renae Jefferies, Office of the Revisor of Statutes
Katherine McBride, Office of the Revisor of Statutes
Ken Wilke, Office of the Revisor of Statutes
Carolyn Long, Committee Secretary

Conferees

Lieutenant Governor Jeff Colyer, M.D.
Sandy Praeger, Kansas Commissioner of Insurance
Robert Moser, M.D., Secretary, Kansas Department of Health and Environment
Robert Siedlecki, Secretary, Kansas Department of Social and Rehabilitation Services
Cathy Harding, Executive Director, Kansas Association for the Medically Underserved (KAMU)
Jason Wesco, Deputy Director, Kansas Association for the Medically Underserved (KAMU)

Other Attending

See attached list.

Morning Session

Chairperson Schmidt called the meeting to order and welcomed those in attendance. She reminded the Committee the next meetings would be on October 25 and November 15, and any questions the Committee may have, should be submitted well in advance of the meeting dates.

Status of Medicaid Reform

Lieutenant Governor Jeff Colyer was welcomed by the Chairperson. The Lieutenant Governor took the opportunity to introduce his daughter, Dominique, and her friend, Mary, who were paging for him for the day. He provided the Committee with a status report on Medicaid Reform (Attachment 1) and pointed out the many challenges the state has. These challenges include 100,000 Kansans out of work, school funding concerns, the Kansas Public Employees Retirement System (KPERS) is several billion dollars short on funds to meet obligations, the need to transform Medicaid to be reconciled with the modern world, and the large budget deficits which could occur even with a large tax increase.

The Lieutenant Governor stated the federal government will 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 indicated these federal cuts with minimum flexibility for states are all but certain, and Kansas must be prepared.

Medicaid is currently 45 years old and was established to assure stable healthcare and better health outcomes, but did not include all health issues, such as diabetes. Medicaid has a complex Federal/State/Patient/Insurer/Provider relationship and current costs will overwhelm Kansas, Lieutenant Governor Colyer stated. He further indicated the state can expect a 400 percent increase in Medicaid expenditures in the next 20 years. The Governor's office has solicited ideas for reforms or pilots to improve quality and control costs by holding public forums, Web surveys, and conferences.

Medicaid transformation principles outlined by the Lieutenant Governor included:

- Providing holistic care focused on outcomes, which includes caring for the whole person; quality results that would improve lives; the need to look at all programs, agencies, tax policy, jobs, and lifestyle of the person; and respect and account for the connection between physical and mental health;

- Creating a strong, dignified, and stable safety net for the most vulnerable Kansans, targeting those most in need;

- Eliminating needless paperwork across the board; creating a program which would be economically rational; linking quality and outcomes to price; aligning health decisions, costs, and quality in the same direction; and having results that mean everyone feels the link between outcomes and costs;

- Assisting people from Medicaid to the workplace by bridging the transition to work and private financing; encouraging the private sector to employ persons

with disabilities; and eliminating the disincentives to employment for persons with disabilities; and

- Rewarding personal responsibility for health outcomes. It is well known that personal health decisions have the biggest impact on quality of life. Medicaid needs to reward personal responsibility, just as private insurers do.

The Lieutenant Governor stated there is a need for a global waiver; some states have had success in initiating this in a limited fashion. 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.

In an effort to prevent waste, fraud and abuse, the Lieutenant Governor expressed that the state needs to move from paper-based enrollment to electronic enrollment to cut delays, reduce the multiple eligibility systems that already exist, and revise contracting systems that could potentially encourage conflicts of interest.

The Lieutenant Governor stressed that coordinated and value care is necessary for better outcomes and would save money. This could be accomplished by assigning a comprehensive care coordinator for the most complex of patients, who in turn could access the range of programs available. An incentive-based funding mechanism would be created to develop a care coordination infrastructure, which would ensure that medical home communication and information travels across all provider types. Health literacy needs to be identified to educate the population about when and where to access care. By implementing a case management structure, a personal relationship is built and coordination of care and services is promoted. The provider's role in fostering health literacy among patients is an important factor to adherence and better outcomes.

Setting specific quality outcomes, investigating the best practices of integrating physical and behavioral health, and reviewing current potential barriers ultimately would align financing around care for the whole person, the Lieutenant Governor stated.

Removing some of the barriers that discourage beneficiaries from earning more in the workplace is a high priority for the Lieutenant Governor. Leveraging current Department of Commerce incentive programs to target employment opportunities for persons with disabilities would allow those who have the skill set and want to work to return to work through a shared program with the state and private employers. Reviewing options to provide value care organizations with the flexibility to provide incentives or shared cost savings could result in health savings accounts for beneficiaries. The health savings accounts could be used to manage expenses for services not covered, with the end result being healthier choices being made by the beneficiary.

In closing, the Lieutenant Governor stated the expansion of social networking and new technology to provide health education and communication with beneficiaries is of utmost importance. He stated that the state's Medicaid Reform Vision Statement is “to serve Kansans in need with a transformed, fiscally sustainable Medicaid program that provides high-quality, holistic care, and promotes personal responsibility.”

A Committee member asked if the care coordinators would be a new program, or if a program currently in place would be used. Lieutenant Governor Colyer stated programs in existence would continue, but additional training would be implemented. Care coordination

would need to be worked out by the various departments. Another Committee member asked about the goal to cut $200-$400 million from the Medicaid program, indicating he did not see any insight as to how this would be accomplished in the Lieutenant Governor's presentation. The Lieutenant Governor responded that the Administration had not set a specific dollar amount yet. The goal of the Administration is to design a program that is the best for Kansas and to deal with the overall budget cuts when they are known, noting that everyone will ultimately share in the cuts. This would be accomplished through legislation and various activities. The Committee member also inquired as to how the Administration would deal with provider fraud. Lieutenant Governor Colyer stated that provider fraud would be dealt with through a system of checks and balances by consumers and be overseen by the Inspector General. With regard to cuts, 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.

A Committee member noted that when going from Medicare to private insurance, many families, especially those with children, turn to HealthWave. She stated if there are pre-existing conditions, the fees become unmanageable. Lieutenant Governor Colyer acknowledged there needed to be a change in options, perhaps a step ladder of shared costs. He acknowledged some programs would not work and would be reviewed in a years time, and the Administration planned to work with the Legislature to come up with solutions.

A Committee member stated that the program, as outlined, would not work. He stated the state cannot have medicine without dollars; this plan would send people back to the emergency rooms, as an alternative; and a cut in Medicaid would result in a loss of quality of patient care. He also noted the Lieutenant Governor did not present any new ideas. Lieutenant Governor Colyer disagreed.

A Committee member asked about possible provider cuts. 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.

Return of Early Innovator Grant

Lieutenant Governor Colyer discussed the return of the Early Innovator Grant. He indicated, beginning in July of this year, the Obama administration began promulgating a number of separate regulations intended to direct the design and implementation of health insurance exchanges in the states. If Kansas had elected to retain the Early Innovator Grant, and thereby adopt the Health and Human Services' (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 Affordable Care Act. 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 (Attachment 2). He further noted the Court's considerations are unclear. Kansas will have to deal with the decision, think and talk about alternatives; and the Legislature needs to have a voice in any decision made. The Lieutenant Governor stated the Early

Innovator Grant was a program to start an insurance exchange approximately one year earlier than the rest of the states, and then share that technology with the rest of the states. Part of that grant money was for that purpose and part was for Medicaid reform, at that time referred to as K-Med. The state instead moved to accept a separate grant to prevent fraud in the system on the front end, the Kansas Eligibility Enforcement System (KEES). The federal government issued 200 pages of exchange implementation regulations, with the final version of these regulations not likely to come out until next summer, with possible changes. (If members wanted a copy of the regulations, the Lieutenant Governor offered to have his office transmit a copy electronically.) If the exchange was implemented, according to the proposed regulations, small businesses would have to submit to their employees a variety of notices regarding their plan; it also would force the insurance exchange to collect and distribute premiums, thereby creating a new intermediary.

The Lieutenant Governor indicated the regulations also contained language allowing the exchange to decide if treatment was inappropriate or too costly with regard to end of life decisions, thereby taking the decision from the doctor and patient. He stated the federal government would regulate certification and consider rate increases, not the state. The state would be subjected to a national reinsurance mechanism, rather than a state rate. Eligibility regulations could conflict with state regulations. The Lieutenant Governor noted the Early Innovator Grant had a time line requiring the state to have a detailed design ready by September 14, 2011, before the Legislature had opportunity to review it. In summary, he stated, since neither the Legislature or the Supreme Court had spoken on this issue, the Administration felt is was not wise to pursue this. He further stated the state can still maintain and reform the current Medicaid program using grants already in place.

A Committee member noted hearing that the Supreme Court was unsure when it would meet, that the exchange had to be in existence by 2014, and that the federal government would be the exchange person. Further, the federal Department of Health and Human Services (HHS) would be required to approve data exchanges by 2013. For states making progress, HHS may issue conditional approval, and then work with the states and monitor them until conditional approval is revoked. Lieutenant Governor Colyer stated the Governor, Lieutenant Governor, department heads, and the Insurance Commissioner are not moving forward on the exchange. Another Committee member reminded the Lieutenant Governor his testimony was part of a formal record and was surprised his remarks were presented only orally. The Committee member requested submission of written testimony to become a part of the permanent record. In response to remarks by a Committee member, who felt that grant monies should have been retained, Lieutenant Governor Colyer stated the greatest concern was to move Medicaid from a paper system to an electronic system and, by turning back the grant, they eliminated having to begin the insurance exchange earlier than the rest of the states. The Lieutenant Governor also stated a new electronic medical system will be implemented and funding has been obtained.

A Committee member said he understood the Governor received a letter from Secretary Sebelius asking for ideas on exchanges. If the Governor has responded, the Committee member asked if the Committee may see his response. Another Committee member asked if there were differences in the two grants: the Early Innovator Grant and the one kept to establish the KEES program. The Lieutenant Governor indicated there were differences, at which time the Committee member requested the Committee be provided with those differences. The Committee member further inquired whether the federal government would establish the exchange if an exchange is not implemented by the state. Lieutenant Governor Colyer indicated the state's opportunity would not be foreclosed, but it would commit the state to unsure mandates.

At the December 2010 meeting, the Committee had endorsed the application for the Early Innovator Grant. A Committee member stated this was done because the current health system required reform and the grant would enable the state to build a health information structure. However, it was indicated the KEES grant would help in this regard. The Lieutenant Governor stated KEES was better as it provided more flexibility in cross-checking other programs, such as food stamps.

A Committee member requested an explanation of the difference between K-Med and KEES. The Lieutenant Governor's stated KEES has a greater mechanism for fraud prevention and can compare data from other programs, such as food stamps and income. The K-Med grant was dramatically restructured into a 90-10 grant. The Committee member further inquired what would happen if the Supreme Court found the Affordable Care Act (ACA) constitutional. Lieutenant Governor Colyer stated Kansas would be in the same boat as 45 other states and federal grants would be available.

Lieutenant Governor Colyer summed up his presentation by stating the previous Administration 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 dictate states to comply with the ACA, then the Administration and Legislature would decide which direction to pursue.

Status of the Health Insurance Exchange

Sandy Praeger, Kansas Commissioner of Insurance, distributed copies of her testimony (Attachment 3) and 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 were 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.

In December 2010, the Kansas Insurance Department was encouraged to work with representatives of the Kansas Health Policy Authority (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 grant, 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.

In January 2011, the Insurance Department held a meeting of 125 individuals representing a wide variety of stakeholders to participate in an exchange planning process. Work groups were formed and began meeting in February. The groups were provided information on various topics related to health insurance exchanges, and were tasked with addressing a wide variety of issues related to the creation of a Kansas exchange. The ultimate goal was the development of recommendations for the operation of a state exchange for presentation to the Legislature and the Governor for consideration during the 2012 Legislative Session.

Commissioner Praeger stated that, to date, there is very little information about how a federal exchange would operate in Kansas. However, if a federal exchange were to occur, it could: impact the operation of the Kansas Medicaid and CHIP programs; result in an "active purchaser" exchange model, rather than an open marketplace approach; determine the extent Kansas agents and brokers are compensated for assisting individuals enrolling in health plans; and result in additional requirements being placed on insurers who wish to participate in the exchange.

Additionally, Commissioner Praeger noted a position paper was received late last week from America's Health Insurance Plans (AHIP) (Attachment 4); it has consistently expressed support for state implementation of exchanges, rather than a federal approach, and the continuation of state regulation of local insurance markets.

At this time, the Insurance Department has 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 currently 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. Level I requires a governor's signature and the last submission deadline is December 31, 2011. Level II grant funding is available only to states that have enacted enabling legislation for a state exchange with a deadline of June 30, 2012.

Commissioner Praeger stated that since the Affordable Care Act was enacted in March 2010, the Insurance Department has implemented and administered the various provisions of the law that have impacted the health insurance market place in Kansas. Until such time as there is a change in the law, the Insurance Department will continue to prepare for full implementation of all requirements, including the health insurance exchange that will begin operation in 2014.

A Committee member asked if any other avenues for funding are available, since the state returned the grant. Commissioner Praeger responded it could be possible, but, at this time, there was no other funding from HHS. Another Committee member inquired if Commissioner Praeger was a part of the original group that rejected the grant, and she indicated she was not. When the Commissioner was asked when she first learned of the return of the grant, she replied that she received a call shortly before the announcement. Since the grant came to the state under the signature of the governor, the Insurance Department could not object.

A Committee member asked how many states received the Early Innovator grant. Commissioner Praeger stated seven states applied and all received the grant. Had all states applied, possibly only five to six states would have been successful in obtaining the grant, she stated.

A Committee member inquired if it was still the intention of the Commissioner to bring bills to the Legislature on how the exchange would be implemented. The Commissioner stated it was her intention to do so. When asked if the state would be eligible for any of the Level I or II grants should the Governor change his position, the Commissioner stated probably not due to the deadlines in place.

A Committee member asked if there was a list of the grant conditions available. Commissioner Praeger stated they were available on the HHS website by accessing provisions

and then rules and regulations. The National Association of Insurance Commissioners (NAIC) website has a user-friendly version that can be downloaded.

A Committee member asked, since the original planning phase began in January 2011 with an end to be in July 2011 when the federal regulations came out, and since the decision was made to continue with the planning, when would the process be finished. Commissioner Praeger said it is the opinion of their IT expert that, if the Insurance Department receives direction to move forward, the Department could still be ready by the end of the next legislative session, but would require additional resources. The Committee member then asked if any of the established work groups had completed their work. Commissioner Praeger responded, to her knowledge, none of the work groups had completed their work.

When asked by a Committee member if her Commission could force health exchange past the Legislature, Commissioner Praeger stated it would be impossible, but she would not do it even if it was possible. When asked if she had heard that the ACA would only fund the state exchanges and not the federal, Commissioner Praeger stated though she had heard, she did not think it would happen. The Committee member then inquired if the federal government would offer an exchange to states that already have a state exchange. Commissioner Praeger stated there would be no dual exchange, although there could be multi-state exchanges. Asked if she had seen any actuarial numbers for rates, Commissioner Praeger said it would depend on the essential benefits package and is 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 choose not to purchase insurance, the Commissioner stated the more participants the exchange has, the more the cost can be spread across the board.

Commissioner Praeger stated, regarding small business, it is known that small groups and companies want to provide insurance to their employees. However, there are no penalties for companies under 50 to participate and that companies would prefer a state-based exchange.

Afternoon Session

Status of the Kansas Medical Eligibility Determination (K-MED) System; Impact of Return of Early Innovator Grant; Kansas Eligibility Enforcement System (KEES)

Robert Moser, M.D., Secretary, Kansas Department of Health and Environment, discussed the Kansas Eligibility Enforcement System (KEES) (Attachment 5). He outlined the program being comprised of four components:

- Determination of eligibility by incorporating what had been known as Kansas Department of Health and Environment's (KDHE's) K-MED program and the Department of Social and Rehabilitation Services' (SRS') AVENUES program on a common platform;

- Protection of the program integrity by using consistent data for each program;

- Reduction of fraud by detecting inconsistencies among various data sources by an automation of program integrity and fraud detection and creating a single information architecture platform. This platform will allow KEES to find inconsistencies in what is reported by applicants. The data also will be cross-referenced with other state and federal data sources to validate or trigger reviews. Examples of cross-referencing will include, but not be limited to child support (enforcement and income), Social Security Administration (multiple files, including citizenship verification), KDHE (vital statistics, immunization records), Kansas Department of Labor (base wage information and unemployment), Kansas Department of Revenue (drivers' license), Blue Cross/Blue Shield premiums, private sector wage verification, Kansas Public Employees Retirement System, and others; and

- Looks Ahead because it can be customized for other state programs, thereby reducing future investments in IT infrastructure.

Secretary Moser explained that KEES will be better for Kansans and will 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 will 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 will help policymakers with more complete and accurate information, and will allow policy changes to be implemented more quickly.

The Secretary stated the first users of KEES will 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 will 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 will continue using the current process. KDHE projects no backlog with current resources.

According to Secretary Moser, 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.

Secretary Moser said that federal funding for KEES is neither a grant nor funded under ACA. 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.

A Committee member inquired whether the Veterans Administration would be woven into the program. Secretary Moser replied that was not the case at this time, but it is possible in the future and that it would be incorporated into the KEES application.

Transition of Kansas Health Policy Authority into Department of Health and Environment Division of Health Care Finance

Regarding the transition of the Kansas Health Policy Authority (KHPA) into the KDHE Division of Health Care Finance (DHCF), KDHE Secretary Moser read Executive Reorganization Order No. 38, which states the following:

> "Sec. 3.(a) The department of health and environment and its division of health care finance shall be the successor in every way to the powers, duties and functions of the Kansas health policy authority in which the same were vested prior to the effective date of this order and that are transferred pursuant to section 2 of this order."

After sharing an updated Organization Chart (contained in Attachment 5), Secretary Moser 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 Secretary Moser are 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, Secretary Moser 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-funded (CDC) 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.

A Committee member asked what happened to the KHPA Board of Directors, who, in his opinion, provided independent feedback to the KHPA. Secretary Moser indicated the Board was dissolved with the reorganization.

A Committee member asked about the status of the mental health preferred drug list. Secretary Moser indicated that the funding came from Lilly and is no longer available. Currently, there is a group of professionals, including psychiatrists, on the patient review committee. The Secretary was asked to provide a list to the Committee.

A Committee member asked if all positions involved in the restructure were filled. Secretary Moser stated that 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.

Impact of SRS Office Closings on Caseloads and Medicaid Application Processing Time

The Chairperson recognized Robert Siedlecki, Secretary, Kansas Department of Social and Rehabilitation Services (SRS), to present testimony (Attachment 6). Secretary Siedlecki said that, when he took office, it was evident 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.

According to the Secretary, 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.

Secretary Siedlecki 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.

The Secretary noted 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. This was already standard practice in the VR Program.

A Committee member asked for the Administration's rationale for not applying for the Community Transformation Grant. Secretary Moser replied there were several reasons. One reason was a requirement that the jurisdiction contain 1.5 million people, meaning that only Johnson County or the entire State of Kansas could apply. Another reason was the inability to use current staff involved with their prevention program and, instead, requiring the hiring of three additional staff in order to be eligible for the grant. Kansas did not qualify for an anti-obesity implementation grant for several reasons; however, the Governor is very interested in moving forward with programs already in place, and developing a board to look into the possibility of Kansas qualifying, if funding is still available in the future.

The Chairperson asked the Secretary to provide the retirement numbers for SRS. He stated that 110 individuals, or approximately 25 percent, had retired. SRS's intention is to back-fill 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.

Update on Safety Net Clinics and Federally Qualified Health Centers; Dental Clinic Grant

Cathy Harding, Executive Director, Kansas Association for the Medically Underserved (KAMU), along with Jason Wesco, Deputy Director, KAMU, presented the update (Attachment 7). Ms. Harding indicated, 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.

Mr. Wesco 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 to 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.

Ms. Harding 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. A list of the requirements for recognition by the NCQA was requested by the Committee. In addition, 17 members are actively working for NCQA recognition.

The Committee also asked for the following information:

- Figures regarding private funding, outside the funding received from the state and federal government;

- The Unused Medication Act information as it applies to the clinics, and the number of practitioners that are participating in the K-TRACK program, along with the number of accounts and sub-accounts; and

- A breakdown on the number of clients that require mental health services.

The Chairperson gave another reminder that the remaining meeting dates were October 25 and November 15. The meeting was adjourned.

Prepared by Carolyn Long
Edited by Iraida Orr

Approved by Committee on:

October 25, 2011
(Date)