MINUTES

JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT

November 15, 2011
Room 346-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
Representative Don Hill
Representative Peggy Mast
Representative Susan Mosier
Representative Louis Ruiz
Representative Jim Ward

Member Absent

Senator Ruth Teichman

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
Bobbi Mariani, Kansas Legislative Research Department
Renae Jefferies, Office of the Revisor of Statutes
Katherine McBride, Office of the Revisor of Statutes
Nobuko Folmsbee, Office of the Revisor of Statutes
Ken Wilke, Office of the Revisor of Statutes
Carolyn Long, Committee Secretary

Conferees

Jeff Colyer, M.D., Lieutenant Governor
Robert Siedlecki, Secretary, Kansas Department of Social and Rehabilitation Services
Shawn Sullivan, Secretary, Kansas Department on Aging
Robert Moser, M.D., Secretary, Kansas Department of Health and Environment
Sandy Praeger, Kansas Commissioner of Insurance
Amy Deckard, Assistant Director of Information Management, Kansas Legislative Research Department
Renae Jefferies, Assistant Revisor of Statutes
Nobuko Folmsbee, Senior Assistant Revisor of Statutes

Others Attending

See attached list.

Morning Session

Chairperson Schmidt called the meeting to order and welcomed Lieutenant Governor Jeff Colyer. The Lieutenant Governor informed the Committee there were several issues before the Supreme Court. The most prominent is the Patient Protection and Affordable Care Act's (PPACA's) mandate requiring individuals to purchase health insurance by 2014. The law has been litigated in various courts, to date. Three U.S. circuit courts have found the law is constitutional, or that the plaintiffs did not have standing to sue. The 11th Circuit Court found the individual mandate to be unconstitutional.

The Supreme Court also will hear arguments on whether the lawsuit challenging the individual mandate is barred by the Tax Anti-injunction Act. Basically, the Court has three options in deciding the individual mandate question. They are:

- To rule that the individual mandate is a proper exercise of Congress' power under the *U.S. Constitution* to regulate interstate commerce, and thus the provision is constitutional;

- To rule that the individual mandate is unconstitutional, but permit the other provisions in the PPACA to be implemented as enacted; or

- To rule that the individual mandate is unconstitutional, and that the particular provision is so integral to the overall framework of the PPACA that it cannot be severed from the law, and thus the entire legislation would be nullified.

The Supreme Court has granted review of whether the PPACA's requirement that states must increase their Medicaid coverage or risk forfeiture of federal Medicaid funding is unduly coercive. If the Court accepts the states' arguments on this question, it could have far-reaching ramifications for other federal spending programs. Oral arguments will be held in February or March, with a ruling by June.

Lieutenant Governor Colyer briefly touched on the fact that the federal government has established the Super Committee (six Republicans, six Democrats) to cut $1.2 trillion plus out of the federal budget. Indications are that the Super Committee is considering the following:

- Potentially changing Federal Medical Assistance Percentage (FMAP) rates;

- Eliminating self-taxes for Medicaid;

- Cutting Medicaid by $70-180 billion over the next decade; and

- Cutting $72 billion from Medicaid over ten years, which would translate to roughly a $720 million cut to Kansas (included in the Obama Administration's offered plan).

Lieutenant Governor Colyer noted the impact of the Super Committee's decisions should be known by Thanksgiving.

Lieutenant Governor Colyer stated the current Medicaid system lacks coherence. He noted managed care companies have profit margins not tied to outcomes. As such, no one is financially culpable for results, and the program is not oriented to meeting the needs of the whole person.

The Lieutenant Governor also provided an Executive Summary entitled *KanCare: Reinventing Medicaid for Kansas* (Attachment 1). Returning to the topic of Medicaid for Kansas, he stated Kansas Medicaid costs have grown at an annual rate of 7.4 percent over the last decade, driven by widespread increases in enrollment and spending per person. Historically, Kansas Medicaid has not been outcome-oriented. He noted only focusing on costs, to the exclusion of quality and outcomes, would be counterproductive. Public input and stakeholder consultation process validated the need for increased accountability in the services the state provides, and for a new level of investment in prevention, care coordination, and evidence-based practice.

The Lieutenant Governor described the Kansas Solution proposal for Medicaid reform, which includes the following:

- Global Waiver
    - Kansas would seek a waiver from the federal government to maximize flexibility in administering the Medicaid program for the benefit of all Kansans. The Kansas approach would be based on the themes of integrated, whole-person care; preserving or creating a path to independence; and alternative access models and an emphasis on home and community based services.
- Person-Centered Care Coordination
    - The reform process has led toward the creation of a comprehensive, integrated, person-centered care coordination program to be named "KanCare," which includes all major populations and services (including those currently provided in fee-for-service, existing managed care, home and community based services, and long-term and institutional care). Details of the KanCare program are:
        - The state would leverage private sector innovation to achieve public goals by issuing a Request for Proposal (RFP) targeting three statewide KanCare contracts;
        - Population-specific and statewide outcomes measures would be integral to the contracts and will be paired with meaningful financial incentives;
        - The reforms would call for the creation of health homes, with an initial focus on individuals with a mental illness, diabetes, or both;
        - The KanCare Request for Proposal (RFP) would encourage contractors to use established community partners, including hospitals, physicians, Community Mental Health Centers (CMHCs), primary care and safety net clinics, Centers for

Independent Living (CILs), Area Agencies on Aging (AAAs), and Community Developmental Disability Organizations (CDDOs);

- Safeguards for provider reimbursement and quality would be included;
- The state would create a contractual obligation to maintain existing services and beneficiary protections; and
- Services for individuals residing in state Intermediate Care Facilities for Individuals with Mental Retardation (ICF-MR) facilities would continue to be provided outside of these contracts.

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

- Medicaid to Work
  - One element of the reform would be to increase opportunities to work, particularly for the disabled Kansans on Medicaid who have indicated their desire to find employment. An enhanced Medicaid to Work program would include collaboration with the Department of Commerce to match potential workers with employers.
  - Other elements included:
    - Reducing disincentives to work by enhancing Working Healthy and Work Opportunities Reward Kansans (WORK) program;
    - Creating a disability preference for state employment;
    - Leveraging state purchasing and incentive policies to encourage contractors to hire people with disabilities;
    - Establishing cash incentives for businesses that hire people with disabilities who currently are receiving state services; and
    - Increasing awareness of the Use Law.

      Legislation may be needed to accomplish this aspect of the plan.

- Realign State Agencies
  - Public interaction with the Medicaid program would be streamlined by an agency realignment that would consolidate Medicaid fiscal and contractual management in the Kansas Department of Health and Environment (KDHE) and Home and Community Based Services (HCBS) waivers and mental health program management in a reconfigured Kansas Department on Aging (KDOA), to be renamed the Kansas Department for Aging and Human Services. The Department on Social

and Rehabilitation Services (SRS) would add select family preservation, social and prevention programs from KDHE and the Juvenile Justice Authority (JJA) to strengthen its targeted focus as a renamed Department for Children and Families Services.

- Savings
  - Based on a conservative baseline of 6.6 percent growth in Medicaid without reforms (actual historic growth rate over the past decade was 7.4 percent), the outcomes-focused, person-centered care coordination model executed under the RFP is expected to achieve savings of $853 million (all funds) over the next five years.
  - As part of the Medicaid Reform Plan, the Lieutenant Governor provided an overview of the Pay for Performance measures (Attachment 2). The pay for performance measures in the first contract year are primarily focused around process measures, rather than outcomes measures due to outcomes taking some time to produce. For the second and third contract years, fifteen measures have been selected by the State as pay for performance (P4P) indicators (five each for physical health, behavioral health, and long-term care). In order to incentivize high performance and quality health outcomes, five percent of each contractor's total per-member, per-month payments would be held back each year for the purpose of incentive payments in years two and three. If the contractor meets quality benchmarks established by the State for each of the 15 selected P4P indicators, the contractor would receive the five percent back in full.
  - The P4P indicators are as follows:
    - Behavioral Health
      - Increased Competitive Employment: An increased number of people with developmental or physical disabilities, or with significant mental health treatment needs, will gain and maintain competitive employment.
      - National Outcome Measures (NOMs): The NOMs for people receiving Substance Use Disorder services will meet or exceed the benchmark in at least 4 of the 5 areas: living arrangements; number of arrests; drug and alcohol use, attendance at self-help meetings; and employment status. The NOMs for people with Severe and Persistent Mental Illness (SPMI) or Serious Emotional Disturbance (SED) receiving mental health services will meet or exceed the benchmark in at least four of these five areas: adult access to services; youth access to services; homeless SPMI; youth school attendance; and youth living in a family home.
      - Decreased Utilization of Inpatient Services: A decreased number of people with mental health treatment needs will utilize inpatient psychiatric services, including state psychiatric facilities and private inpatient mental health services.

- Improved Life Expectancy: The life expectancy for people with disabilities will improve.
- Increased Integration of Care: The rate of integration of physical, behavioral (both mental health and substance use disorder), long term care and HCBS waiver services will increase.

– Long-Term Care

- Nursing Facility Claim Denials: The Managed Care Organization (MCO) will meet or exceed the benchmark for denial of nursing facility claims.
- Fall Risk Management: The number of people at risk of falling will be seen by a practitioner and receive fall risk intervention.
- Decreased Hospital Admission After Nursing Facility Discharge: The percentage of members discharged from a nursing facility who had a hospital admission within 30 days will be decreased.
- Decreased Nursing Facility Days of Care: The number of nursing facility days used by eligible beneficiaries will be decreased.
- Increased use of PEAK (Promoting Excellent Alternatives in Kansas) Certified Days of Care: The percentage of nursing facility days for services in PEAK-certified person centered care homes will be increased.

– Physical Health

- Comprehensive Diabetes Care: This measure is actually a composite Health Plan Employer Data and Information Set (HEDIS) measure composed of ten rates. To be considered compliant with this measure, the contractor must meet or exceed the benchmark rate for hemoglobin A1c (HbA1c) screening and meet or exceed the benchmark for seven of the remaining nine Comprehensive Diabetes Care rates following all required HEDIS methodology.
- Well-Child Visits in the First 15 Months of Life: The Contractor shall meet or exceed the benchmark using HEDIS methodology and specifications.
- Pre-term Births: The Contractor shall utilize Joint Commission National Quality Measures methodology and meet or exceed the State-defined benchmark.
- Annual Monitoring for Patients on Persistent Medications: The Contractor shall meet or exceed the benchmark using HEDIS methodology and specifications.
- Follow-up after Hospitalization for Mental Illness: The Contractor shall meet or exceed the benchmark using HEDIS methodology and specifications.

The Lieutenant Governor also shared the principles used by the current Administration to guide them in reform, as they felt the present system was not acceptable. The following were several of the principles considered in that process:

- Improve patient outcomes and health for Kansans;
- Encourage integrated care for the whole person;
- Preserve and stabilize the safety net long term;
- Encourage private financed healthcare;
- Not arbitrarily cut off large numbers of Kansans from Medicaid;
- Avoid large double-digit provider cuts that could harm patient care;
- Prepare for projected announced federal cuts to Kansas Medicaid and Kansas budget issues;
- Encourage personal responsibility, discourage dependency, and make programs more economically rational; and
- Share the sacrifice; and share the results.

The Chairperson thanked the Lieutenant Governor for his presentation and asked him to submit his remarks in writing to the Committee along with an explanation of the 15 points outlined in his presentation. The Lieutenant Governor provided written information after the Committee meeting (Attachment 3).

In response to Committee member comments, the Lieutenant Governor agreed there is frustration with the mental illness follow-up system. He stated Kansans are frustrated by the cuts in programs, having difficulty getting into a facility for treatment, and not knowing who to turn to when they need help.

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

Robert Siedlecki, Secretary, Kansas Department of Social and Rehabilitation Services (SRS), appeared before the Committee in response to the reorganization of departments within state government as part of the state's Medicaid Reform Plan (Attachment 4). He stated SRS would continue to interact with and provide assistance to about 500,000 Kansans each year. SRS would continue to administer programs and provide services, ranging from food assistance to child care assistance; help with securing child support payments; continue to be concerned with the safety of children and vulnerable adults; and continue to work with providers, such as child welfare contractors, child care providers, and adoption providers.

The new SRS responsibilities, which would transfer from the Kansas Department of Health and Environment (KDHE), include: licensing of child care facilities and foster care homes; providing infant-toddler services; providing services to children and youth with special needs; and continuing the Maternal, Infant and Early Childhood Home Visitor Program, the Pregnancy Maintenance Initiative, abstinence education, the Healthy Families program, and teen pregnancy prevention efforts.

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

Secretary Siedlecki indicated this reorganization of state government is a reflection of KanCare programs and the way the programs are financed. It is a rational way of aligning programs and their administration under a managed care plan that encompasses all aspects of care: physical, mental and rehabilitative. The reorganization would allow the state to deliver integrated, whole-person care in the most efficient way possible.

In response to Committee questions, Secretary Siedlecki stated:

- SRS would work with the Departments of Commerce and Labor to identify available jobs in an effort to get the poor and disabled back to work, stating the need to work with individuals, taking in their need for transportation and the tools to be successful, and doing everything within his power to see that this happens.

- In acquiring the prevention, intake and assessment functions from JJA, Secretary Siedlecki stated he felt SRS is in a better position to administer prevention programs to keep youth out of the system, acknowledging that some are already in the system through child care services.

- SRS is going to be more aggressive with fraud concerning Vision cards. SRS intends to hire additional investigators and implement a program where if a Vision card is lost three times, the individual would be unable to receive a replacement card until a visit to the SRS office is made to explain the loss. SRS also would work with individuals if the repeated card loss is a result of a disability or mental health issue.

- Drug testing for people receiving benefits has its merits, but details in implementing such a program are numerous. He stated that if the beneficiaries are on drugs, help with that issue would need to be provided first.

- Food stamp fraud is a large issue and, unfortunately, merchants are one of the biggest offenders. Some possible solutions could be to put some identification on cards or even a strip on a beneficiary's driver's license.

State employees working in programs affected by the reorganization most likely would be given the opportunity to move with their program.

Shawn Sullivan, Secretary, Kansas Department on Aging (KDOA) updated the Committee on the impact of the re-organization on KDOA (Attachment 5). Secretary Sullivan stated the reasons for the re-organization were the following:

- Restructure agencies to reflect KanCare programs and their financing, and to highlight children and families;

- Streamline consumer and provider interactions with agencies;

- Combine Medicaid Home and Community Based Services waivers into one department;

- Make implementation of the Aging and Disability Resource Center (ADRC) concept easier;

- Reduce fragmentation and silos between populations and provider groups;

- Have dual eligibles (those eligible for Medicaid and Medicare) within one agency; and

- Prevent creation of a mega-agency.

An overview of the State Fiscal Year (SFY) 2012 KDOA budget showed proposed disbursements as follows: nursing facilities $439.1 million; home and community based services for frail and elderly $75 million; program of all-inclusive care for the elderly (PACE) $4.9 million; targeted case management $5.1 million; Community and Nutrition $22.7 million; and operations $13.5 million, for a total of $560.3 million.

The SFY 2012 budget for state hospitals shows Kansas Neurological Institute at $29,414,663; Larned State Hospital at $59,312,663; Parsons State Hospital at $25,746,573; and Osawatomie State Hospital/Rainbow Mental Health Facility at $29,454,105.

The proposed organizational chart shows six departments within the Department for Aging and Human Services:

- Office of the Secretary;
- Financial and Information Services;
- State Hospitals;

- Regulatory Services;
- Division on Aging; and
- Community Services and Supports (Waiver Services and Mental Health/Substance Abuse).

Questions by Committee members arose regarding the status of the repairs to be made to the Rainbow Mental Health Center. Secretary Siedlecki responded to this line of questions. He indicated some patients already have been moved, with repairs to begin soon and to take six to eight months. He further stated that Rainbow will remain open, and eight beds will remain available on the site for emergency situations occurring during the renovation process.

When asked by a Committee member if additional office space would be required for the agency, Secretary Sullivan indicated it was yet to be determined. Implementation of the proposed re-organization would begin with the introduction of an Executive Reorganization Order (ERO) within the first 30 days of the 2012 Legislative Session, with a proposed effective date of July 1, 2012.

Dr. Robert Moser, Secretary, Kansas Department of Health and Environment (KDHE) reviewed the impact of the reorganization on KDHE and included in his presentation an update on the Kansas Eligibility Enforcement System (KEES) and the Newborn Screening Program (NBS) (Attachment 6).

Under the proposed reorganization, there would be four divisions within KDHE:

- Operations (Office of the Secretary, Communications. Management and Budget, Information Technology and Legal Services);

- Division of Public Health (Center for Health Disparities, Center for Performance Management, Community Health Systems, Oral Health, Disease Prevention and Control, Environmental Health, Health Promotion, Epidemiology and Public Health Informatics);

- Division of Health Care Finance (Responsible for KanCare fiscal and contract management, State Employee Health Plan); and

- Division of Environment (Air, Waste Management, Water, Environmental Remediation, Environmental Field Services, Health and Environmental Laboratories).

KDHE programs moving to the Department for Children and Families under the proposed reorganization include:

- Child Care Licensing;
- Foster Care Licensing;
- Infant and Toddler Services;
- Children and Youth with Special Health Care Needs;
- Maternal, Infant and Early Childhood Home Visitor Program;
- Healthy Start Home Visitor Program;

- Pregnancy Maintenance Initiative;
- Abstinence Education; and
- Teen Pregnancy Prevention.

Health regulatory functions would move to the Department for Aging and Human Services. KanCare fiscal and contract management would move to the KDHE Division of Health Care Finance (DHCF).

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

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

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

Secretary Siedlecki returned to the podium to update the Committee on the closure of several SRS community service centers (Attachment 7). The Secretary stated the SRS budget for FY 2012 forced the Department to find $42 million in savings over the next year. A number of ways to close this gap in the SRS budget were identified, including:

- Delaying computer purchases;
- Eliminating association dues and subscriptions;
- Holding regional office operating expenditures at FY 2011 levels;
- Reducing most grants and contracts by three percent; and
- Eliminating specific grants.

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

SRS intends to ask the Legislature to restore funding for the five community service centers remaining open, because the local communities have agreed to pay the state's cost. That funding request will be in the SRS final FY 2013 budget proposal. There are no anticipated further closings; however, this may need to be re-evaluated should the budget be cut drastically and the agency forced to find further savings.

A Committee member requested a status update on the Information Release Form used by SRS, which was discussed at the previous Committee meeting, with concerns expressed at that time that the form was overly broad. The Secretary indicated that SRS Counsel is reviewing the form and the Committee will be kept informed as to the Counsel's findings.

Amy Deckard, Assistant Director of Information Management, Kansas Legislative Research Department (KLRD), presented the Fall Human Services Consensus Caseload Estimates for FY 2012 and FY 2013 (Attachment 8). The Division of the Budget, SRS, KDHE, KDOA, JJA, and KLRD met on November 2, 2011, to revise the estimates on human services caseload expenditures for FY 2012 and to make initial estimates for FY 2013. The combined increase for FY 2012 and FY 2013 is an all funds increase of $173.6 million and a State General Fund (SGF) increase of $72.1 million.

Ms. Deckard noted the responsibility for most health care services for persons who qualify for Medicaid, MediKan, and other state health insurance programs were transferred to KDHE, Division of Health Care Finance, on July 1, 2011, as directed in Executive Reorganization Order (ERO) No. 38. Certain mental health services, addiction treatment services, and services for persons with disabilities that are a part of the regular Medical Assistance Program remain in the SRS budget.

Ms. Deckard stated she would provide information regarding a Committee member question on the nursing facility expenditures decrease of $6.7 million from all funding sources and an increase of $770,000 from the SGF. Another Committee member requested fiscal information be provided showing the changes made as a result of reductions by the federal government versus changes made by the state, and the reasons the changes were made.

Renae Jefferies, Assistant Revisor of Statutes, Office of the Revisor of Statutes, (Attachment 9), brought KSA 2011 Supp. 46-3501, the statute establishing the Joint Committee on Health Policy Oversight, to the attention of the Committee. Under current statutory provisions, the Committee is to “monitor and study the operations of the Kansas Health Policy Authority” (KHPA), in addition to overseeing the implementation and operation of the State Childrens Health Insurance Program (HealthWave). ERO No. 38 abolished the KHPA and placed its duties under the Division of Health Care Finance within the Department of Health and Environment. With this abolishment, the charging statute which sets out the Committee's duties is no longer accurate due to its references to the KHPA. It also was noted that the provisions of the statute are set to expire on July 1, 2013.

A motion was made to amend KSA 2011 Supp. 46-3501 by replacing the Kansas Health Policy Authority with the Division of Health Care Finance within the Kansas Department of Health and Environment, and to amend the statute to include oversight of general state health care policies. It also was moved the sunset date be changed to July 1, 2017 (Attachment 10). (Motion by Representative Ward, seconded by Senator Reitz.) The motion was left open until the afternoon session.

Nobuko Folmsbee, Senior Assistant Revisor of Statutes, Office of the Revisor of Statutes, explained and presented a draft of a trailer bill for ERO No.38 that was approved for introduction at the October 25, 2011, meeting. The trailer bill makes no policy changes, but only makes needed statutory changes as a result of the passing of ERO No. 38. Ms. Folmsbee indicated the trailer bill will be pre-filed.

Afternoon Session

The motion currently open on the floor passed.

The minutes for the October 25, 2011, meeting were approved. (Motion by Representative Ruiz, seconded by Senator Reitz.)

Sandy Praeger, Kansas Commissioner of Insurance, updated the Committee regarding information obtained on the Federally Facilitated Exchange (FFE) and the State/Federal Partnership Model Exchange (Attachment 11). At a meeting in September, hosted by Health and Human Services (HHS), officials provided information to states regarding the federal government's vision for a Federally Facilitated Exchange and a State/Federal Partnership Model. In that presentation, HHS defined the five core functions of an exchange as: Consumer Assistance, Plan Management, Eligibility, Enrollment, and Financial Management.

There are three options for a Kansas exchange: a state-operated exchange, a federally facilitated exchange (FFE), or the state/federal partnership model. However, the possibility for a state-operated exchange would be contingent upon the passage of enabling legislation during the 2012 Legislative Session. It also would be contingent upon obtaining funding for the implementation of an exchange. The deadline for applying to HHS for a Level 1 Establishment Grant is December 30, 2011, and would require a letter of support from the Governor for the grant application. The Level II Establishment Grant deadline is June 29, 2012, but only is available to states that have enacted exchange enabling legislation. There is no requirement that a Level I grant has been obtained in order to apply for a Level II grant.

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

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

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

Commissioner Praeger stated Kansas could apply for the Level I grant if the Governor signed the letter. She did not know if a Committee request to the Governor would help in the decision making process. Commissioner Praeger indicated, if the Governor were to sign a letter for Phase I funding, the Insurance Department would be ready to proceed. She noted it has always been the intention of the Insurance Department to be prepared to keep as much of the decision-making as possible at the state level. Regarding the cost to the state if the state were unable to get funding and a federal exchange was created, the Commissioner indicated there may be some state cost. The federal government would use the money set aside for a state exchange to develop a federal exchange in the state for the first year of the exchange. After the first year, the exchange would have to be self-sustaining with the use of transaction fees.

The Committee turned its attention to a discussion for the purpose of reaching conclusions and making recommendations to the 2012 Legislature, including direction to Committee staff for the Committee Report to the Legislative Coordinating Council. The items for consideration presented by the Chairperson were:

- **Newborn Screening Program.** Encourage KDHE to consider exploring funding options for the Newborn Screening Program and to consider presenting to the 2012 Legislature any legislation needed to address the funding needs or changes.

- **KEES.** The Committee received information about the KEES program and the time line for implementation.

- **Committee Authority.** *The Committee recommends a trailer bill be presented during the 2012 Legislative Session to accompany the motion passed to amend the authorizing statute (KSA 2011 Supp. 46-3501) by replacing the references to the "Kansas Health Policy Authority" with the "Division of Health Care Finance within the Kansas Department of Health and Environment" and to amend the statute to include oversight of general state health care policies. It was also moved that the sunset date be changed to July 1, 2017*.

- **Medicaid Reform/Managed Care/Medicaid Reimbursement Rates.** Encourage consideration of a close review of managed care contracts, prior to funds being appropriated by the Legislature, to ensure contracts stipulate that no cuts in Medicaid reimbursement rates will be made.

- **Dental.** Encourage further consideration of expansion of the Medicaid program to include adult dental services.

- **KU Medical School/Smokey Hill Family Medicine Residency Program in Salina.**

    - Consider supporting the Kansas University School of Medicine program's need for a new medical education building to replace the present facility,

the plans to create a school of public health focusing on preventative medicine, and the development of individual in-home monitoring services through telemedicine; and to consider funds necessary to accomplish these plans.

The Committee received testimony regarding the effectiveness of the University of Kansas School of Medicine and the Smoky Hill Family Residency Program in Salina in serving rural areas and the number of physicians practicing in rural areas who are graduating from these programs.

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

  The Committee received testimony regarding the anticipated increase in demand for medical services and the continued need for medical service in rural areas.

- **SRS Office Closures.** The SRS Secretary stated he would pursue funding for the SRS offices proposed for closure which remain open as a result of contracts between SRS and local government entities. The Committee would request that a status update be provided by SRS on the pursuit of funding for these offices.

- **Health Insurance Exchange.** Recognize the work of the Kansas Insurance Department in continuing the planning process for a health insurance exchange.

The Committee received testimony about the uncertainty of the outcome of the Supreme Court's ultimate ruling on the Patient Protection and Affordable Care Act (PPACA). The desire expressed by conferees was, if a health insurance exchange is required, a state version would be preferred over one established by the federal government.

The Chairperson requested any additional recommendations for consideration from the Committee members. Representative Reitz requested the Committee annually address the issue of infant mortality. He indicated the Committee should remain informed with regard to the state's infant mortality rate; obtain data comparing the state's rate with those of other states and the national rate; and consider the nature of the rate as it pertains to factors such as culture, race, and urban and rural populations.

Senator Brungardt indicated the aforementioned items represented a consensus of the Committee. There were no objections. One conferee expressed a preference for a revision by the state if a health insurance exchange is required, rather than one established by the federal government and operated by a non-profit entity. The issue of operation by a non-profit entity was not considered in the consensus.

Representative Ward presented two findings on the health insurance exchange for Committee consideration which were met with objections and were given separate consideration. The proposed findings were:

- It is in the best interest of citizens of Kansas the state develop an insurance exchange; and

- The State of Kansas should take all necessary steps to minimize the effect of a heath insurance exchange on the State General Fund and pursue Phase I and II Establishment Grants from the federal government.

The Committee discussed the proposed findings, noting the Interim Special Committee on Financial Institutions and Insurance was tasked with addressing the topic of the implementation of a state-based insurance exchange. A request was made of Melissa Calderwood, KLRD lead staff for the Interim Special Committee on Financial Institutions and Insurance, to provide a summary of that Committee's recommendations with respect to a state-based insurance exchange. Ms. Calderwood presented an overview of the recommendations made by the Special Committee.

After continued discussion, the Committee members did not come to a consensus on the findings proposed by Representative Ward. *It was moved by Representative Ward, and seconded by Senator Reitz, the Committee Report to the 2012 Legislature include a recommendation encouraging all state agencies to pursue all available federal funds to assist in the development of a Kansas-run health insurance exchange. The Motion passed, with Representatives Landwehr and Mast voting nay as to the portion of the recommendations related to the implementation of a state-based health insurance exchange.*

The following documents were distributed to the Committee, as a result of requests made at the October 25, 2011, meeting:

- Average age of dentists who are members of the Kansas Dental Association (Attachment 12);
- Kansans Studying at the University of Missouri-Kansas City School of Dentistry Returning to Practice in Kansas; and Medicaid Recovery Audit Contract (RAC) Process (Attachment 13);
- Follow up Information on the Kansas and Missouri Reciprocal Tuition Agreement (Attachment 14);
- Age of Dentists in Kansas (Attachment 15);
- Kansas' CMS 416 Report (Attachment 16);
- Mapping the Rural Kansas Dental Workforce—September 2011. Implications for Population Oral Health (Attachment 17);
- Kansas Donated Dental Services (DDS) Program Annual Report (Attachment 18);
- Kansas County Health Rankings 2009 (Attachment 19);
- Kansas County Health Rankings 2009—Indicators (Attachment 20); and
- Kansas State Fire Marshal's Office—KSFM Violation Notice (Attachment 21).

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Approved by the Committee on:

December 19, 2011
(Date)