MINUTES

JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT

December 19-20, 2012
Room 548-S—Statehouse

Members Present

Senator Vicki Schmidt, Vice-chairperson
Senator David Haley
Senator Laura Kelly
Senator Roger Reitz (Wednesday only)
Representative Don Hill
Representative Peggy Mast (Wednesday only)
Representative Kelly Meigs (Wednesday only)
Representative Louis Ruiz (Wednesday only)
Representative Jim Ward (Wednesday only)

Members Absent

Representative Brenda Landwehr, Chairperson
Senator Pete Brungardt
Senator Ruth Teichman

Staff Present

Iraida Orr, Kansas Legislative Research Department
Melissa Calderwood, Kansas Legislative Research Department
Martha Dorsey, Kansas Legislative Research Department
Katherine McBride, Office of the Revisor of Statutes
Ken Wilke, Office of the Revisor of Statutes
Renae Jefferies, Office of the Revisor of Statutes
Debbie Bartuccio, Committee Assistant

Conferees

Rachel Berroth, Director, Bureau of Family Health, Kansas Department of Health Environment
Linda Logan, Curriculum and Training Consultant, Kansas Child Care Training Opportunities, Manhattan
Leadell Ediger, Executive Director, Child Care Aware of Kansas, Salina
Mark Dugan, Chief of Staff, Lt. Governor's Office
Robert Moser, M.D., Secretary, Kansas Department of Health and Environment
Kari Bruffett, Director, Division of Health Care Finance, Kansas Department of Health and Environment
Shawn Sullivan, Secretary, Kansas Department for Aging and Disability Services

Others Present

See attached list.

Wednesday, December 19

Vice-chairperson Schmidt called the meeting to order at 10:00 a.m. and welcomed all attendees. She reported Chairperson Landwehr sent her regrets she is unable to attend the Committee meetings. The Vice-chairperson reminded Committee members they will have the opportunity to make recommendations for inclusion in the Committee Report to the 2013 Legislature.

Day Care Update

Update on Lexie's Law

Rachel Berroth, Director, Bureau of Family Health, Kansas Department of Health and Environment (KDHE), provided an update on Lexie's Law and the Child Care Licensing (CCL) program. Effective July 1, 2012, the Child Care Licensing Program merged with the Bureau of Family Health. She said the merger has afforded the program with additional opportunities to promote policies and resources for the protection, health, and safety of children in out-of-home care settings and to support families in their efforts toward economic self-sufficiency.

Ms. Berroth stated the provisions of Lexie's Law were fully implemented within the past year. Passed by the Legislature in 2010, Lexie's Law increased health and safety protections for children in day care homes. The provisions included:

- Eliminating the category of registered family day care home and requiring the inspection of all child care facilities;
- Issuing licenses with an expiration date and sticker;
- Requiring the adoption of additional health, safety, and supervision regulations; and
- Developing an online information dissemination system, which provides survey findings.

Eliminating Registered Family Day Care Homes

According to Ms. Berroth, there were approximately 7,800 child care facilities prior to Lexie's Law, and 2,400 of these were registered homes (Attachment 1). She reported the transition of registered homes to licensed homes (occurring from July 2010 to June 2011) has been successful, and the annual surveys confirm previously registered providers are in substantial compliance. Ms. Berroth stated, as of December 2012, the total number of child care facilities is 6,400, with the capacity to serve 140,400 children. The majority of facilities are licensed as day care homes (5,100). The current capacity to serve children in Kansas remains higher than the 2010 capacity (139,000).

Ms. Berroth indicated the transition from non-expiring child care licenses to expiring licenses also has been successful. The transition began with KDHE issuing initial and renewal licenses with an annual expiration date in January 2011; all owners licensed prior to that time received a new license by January 2012 with an expiration date and official sticker. She stated KDHE provides notice of the license renewal requirement by sending a renewal packet to licensees approximately 90 days prior to expiration. Approximately 30 to 40 days prior to the expiration, a second notice in the form of a yellow postcard is sent to facilities that have not renewed. According to Ms. Berroth, on average, only six to ten licenses out of approximately 450 expire each month due to a failure to renew. The majority are reinstated within 30 days, prior to a late fee authorized by Lexie's Law, upon receipt of a completed renewal application. After 60 days, if the renewal application and fees are not received, the facility file is closed and a closure letter is sent to the licensee. She said the option to reapply always is available.

Health and Safety Regulations

Ms. Berroth stated regulations (effective February 3, 2012 for new applicants and May 1, 2012, for providers licensed prior to February 3, 2012) address the competent supervision of children in day care homes; orientation for applicants and staff; additional health and safety training for caregivers; and standards for safe sleep practices, daily activities for children, and nutrition. She reported that as a result of the new requirements, the Kansas ranking in the 2012 National Association of Child Care Resource and Referral Agencies (NACCRRA) Report of State Standards and Oversight of Small Family Day Care Homes rose from 41 (in the 2010 NACCRRA Report) to third in the nation. The link to the full report was provided in the testimony.

According to Ms. Berroth, during state fiscal year 2012, local surveyors provided new regulation training to 2,734 individuals and applicant orientation to 2,534 individuals (2,285 home providers, 249 center staff). She stated the new supervision regulations apply only to the home day care providers, and it was not necessary to amend the regulations for day care centers. The intent of the expanded regulations was to provide additional guidance and direction to caregivers concerning the competent supervision of children, based on the age and development of the children in care.

Ms. Berroth said providing education and training are crucial to preparing applicants for operating a facility and reducing the predictable risk of harm to children. The new regulations require health department orientation for applicants and facility and regulatory orientation for new staff. In addition, health and safety training is required for all center-based staff and home providers, including training in these areas: recognizing the signs of child abuse, neglect, and abusive head trauma and the reporting requirements; basic child development; and safe sleep practices. She reported all caregivers now are required to maintain current certification in pediatric first aid and cardiopulmonary resuscitation (CPR).

The following statewide partners offering KDHE-approved training, in either classroom settings or online, were reported by Ms. Berroth: local health departments, Child Care Aware of Kansas and network child care resource and referral agencies, KS-Train, Kansas Child Care Training Opportunities (KCCTO), Kansas Children's Service League (KCSL), Kansas Infant Death and SIDS (KIDS) Network, and local community colleges. During Fiscal Year 2012, local surveyors provided or co-sponsored 1,400 clock hours of child care training delivered to 9,212 participants. In addition to external training course approvals, KDHE reviewed and approved 310 course offerings. She stated all of the required six hours of coursework are available online and provided at the local level in communities across the state.

A Committee member asked which organizations provide the training. Ms. Berroth referred to the list in her testimony, but she added a number of private individuals and organizations also provide training resources.

Ms. Berroth's statement that the agency is doing the best it can resulted in comments and questions from a Committee member. The Committee member's concern was whether financial support is being provided to accomplish what needs to be done. She replied the Bureau is underfunded and deals with vacancies, but staff are passionate and committed. However, she also noted the work cannot be completed in an eight-hour work day, and KDHE relies on its partners to work together and share resources. The agency continually reviews priorities and mandates to determine what has to be shelved when adequate funding is unavailable. She stated she has been very impressed with what has been accomplished with the available funding. A Committee member expressed concern about the movement in Kansas to not fund programs adequately and emphasized the importance of informing legislative members of program funding issues needing to be addressed.

A Committee member asked for information concerning the type of background checks and mental health evaluations being performed on day care providers and staff. Ms. Berroth reported the current regulations require a Kansas Bureau of Investigation (KBI) background check (including juvenile records), a check by the Kansas Department for Children and Families (DCF) of the Child Abuse Registry, and a health assessment completed by a physician. Individuals are not licensed until all of those checks are clear. A review of the individual's mental health is part of the health assessment and is required at the time of opening a child care facility. She stated the health assessment never has to be reviewed or renewed. The Adult Health Assessment form used is available online for review. Child care regulations require a person be of sound judgment. If an issue of fitness to care for children arises, additional information is gathered. A formal process is in place and involves a review by the legal department. If KDHE has authority to deny the license and the information gathered supports a denial, the license will be denied, she said.

Online Information Dissemination System

Ms. Berroth stated the Child Care and Early Education Portal system is part of a larger joint technology initiative between DCF and KDHE, known as the Customer and Provider Portal (CAPP). The information displayed online is made possible through an interface with the KDHE licensing database (CLARIS). Facility addresses and phone numbers are not displayed unless applicants and licensees authorize it. Lexie's Law requires inspection findings be made available.

According to Ms. Berroth, KDHE has been accepting feedback related to the usability and information displayed on the portal from providers, users, and the Budget Efficiency Savings Team (BEST) since March 2012 and has submitted defects, enhancements, and change requests to DCF. As of February 2012, annual inspections are done online through the use of tablets out in the field. The only specific citings on the portal will be those since February 2012; earlier citings will be noted on the portal, but specific details will not be available. Ms. Berroth indicated every facility soon will have its most recent annual inspection online for review. Use of the portal has grown steadily, averaging 4,000 “hits” per month. Ms. Berroth said she has been tracking all e-mails with suggestions, questions, and other information related to the portal system.

Concerns and Issues with the Existing Child Care Law

Ms. Berroth stated all concerns with the child care law were addressed during the 2012 Legislative Session by HB 2660, which was passed and became law July 1, 2012. The bill amended laws concerning maternity center and child care facility licensure, including the 2010 amendments referred to as Lexie's Law. She noted the following changes were made by the bill and were consistent with the interests of the State, providers, and parents in protecting children, while assuring access to child care:

- Defines a "day care facility" as a type of child care facility; the term is used when provisions of the Act, including the requirement for a high school diploma or the equivalent, apply to day care facilities, including day care homes, preschools, child care centers and school age programs; and

- Authorizes the Secretary of KDHE to grant an exception to the high school diploma requirement when an applicant for a day care facility is otherwise qualified, and the exception is in the best interests of all children in care.

Liability Insurance Requirements for Child Care Facilities

Ms. Berroth reported administrative regulations for child care centers and preschools require the licensee to carry liability insurance in the event of negligence as a recourse for parents. No similar requirement exists for day care homes, group day care homes, and school age programs. She cited the National Association for Regulatory Administration 2008 Child Care Licensing Study, which reported six states require small family day home providers to carry general liability insurance and only eight states require large and group day care homes to have coverage. She stated a bill was introduced in 2006 to require licensed day care home providers to carry liability insurance, but it did not pass. The bill had proposed a minimum coverage of $100,000.

A Committee member asked for the 2006 cost of $100,000 general liability insurance coverage. Ms. Berroth responded she recalled it was about $350 per year.

Online Child Care Application

Ms. Berroth testified the online child care application (available February 2013) will allow providers the option to enroll with DCF to serve families receiving child care subsidies, thereby eliminating the need to submit separate paper applications to each agency. She noted completion of the project will significantly reduce the length of time necessary to submit and process an initial or renewal application, reducing the time it takes to issue a license.

Ms. Berroth submitted the following two documents:

- New and Amended Regulations for Day Care Homes, Child Care Centers and Preschools effective February 3, 2012 (Attachment 2); and

- Child Care and Early Education Portal screen shots (Attachment 3).

A Committee member asked whether Ms. Berroth had received feedback regarding the portal that had led to interactions, interventions, or investigations. Ms. Berroth stated she had not received any feedback of this nature. She indicated the questions received from parents related to the need for basic information, such as how to use the system to review a prospective child care home.

Another question raised by a Committee member concerned the security of the information available on the portal. Ms. Berroth reported the portal is only a placeholder for data and only KDHE has access to the system for editing purposes. KDHE surveyors cannot make changes in the licensing system.

The Vice-chairperson recognized Linda Logan, Curriculum and Training Consultant, Kansas Child Care Training Opportunities (KCCTO), Manhattan, to present her testimony. Ms. Logan reported KCCTO was incorporated in 1986 and is governed by a board of directors representing state agencies and organizations concerned with quality child care for Kansas children (Attachment 4). Its mission is to help promote quality child care by providing training for child care professionals that is comprehensive, low-cost, and accessible. She stated she personally has over 30 years' experience in the field of child care services.

In response to Lexie's Law, Ms. Logan reported KCCTO began offering Child Development and Child Abuse and Neglect: Identification, Reporting and Prevention online courses. She indicated the design of the three-hour course was intentional because KCCTO wanted to include prevention, not just identification and reporting. Since January 2012, over 1,800 child care providers from 90 counties have participated in the online courses. She noted participants in the online courses have included center-based staff, new and existing family child care providers, and staff from Head Start, Early Head Start, and an early childhood staffing agency. As of January 2013, KCCTO will begin offering a course on Infant Safe Sleep Practices to meet Lexie's Law requirements. Other courses also are available on topics extending beyond the requirements of Lexie's Law and include Healthy Routines, Behavior and Guidance, Signs and Symptoms of Childhood Illness, Nutrition and Oral Health.

Ms. Logan indicated she initially had concerns with the online courses replacing the face-to-face training courses. However, with the level of interaction being provided in these courses, she stated connections are being made and the results have been very positive. She also indicated participants are appreciative of the online availability and low cost of the courses. The flexibility of the online format and schedule has allowed participants to meet the 30-day requirement for applicants seeking new licensure. She further noted new providers and experienced providers train together in the classes, resulting in good learning and sharing experiences for the new providers.

When the courses initially were offered in January 2012, Ms. Logan noted the courses were unfunded and funding was accomplished through course fees. As of October 1, 2012, KCCTO entered into a contract with DCF to provide early childhood workforce development. According to Ms. Logan, many of the participants have shared they have learned new terms, such as "shaken baby syndrome" and the "period of purple crying." She stated, because the online courses are instructor led, there are good opportunities for the instructor to address issues and answer questions as they occur.

A Committee member asked if the instructor has the ability to follow up with course participants and whether participants may contact the instructor. Ms. Logan indicated she provides her e-mail and phone number, and she also has all of the participants' e-mail and

phone information, which enables effective communication. She further noted post-facilitation and training information is provided, as initiated by the providers.

Another Committee member inquired as to the availability of course information to non-English speaking providers. Ms. Logan responded the option was not available at this time, but KCCTO was moving in that direction. KCCTO has made an initial contact with the Language Department at Kansas State University regarding options available to provide courses for non-English speaking providers. The Committee member offered to provide information on other groups that may be interested in assisting with the project.

A question was raised by a Committee member concerning the cost of the training classes. Ms. Logan responded the cost generally is $20 per class. In some cases, for every five courses taken, the provider receives one course free of charge.

A Committee member asked about funding. Patty Peschel, KCCTO Program Director, stated KCCTO is a sponsored program of Kansas State University. Kansas State University provides the space for KCCTO and some of the funding, a grant was provided by DCF in October 2012, and some funding has been provided by non-profit entities.

The Vice-chairperson recognized Leadell Ediger, Executive Director, Child Care Aware of Kansas, to provide testimony before the Committee. Ms. Ediger stated the goal of Child Care Aware is to ensure children in Kansas have access to safe child care that promotes healthy development (Attachment 5). She explained Child Care Aware is the state network that supports six child care resource and referral agencies serving all 105 counties in Kansas by:

- Ensuring families have access to affordable, high-quality child care across the state, through child care referrals and consumer education. Over 17,000 families have been helped this year;

- Supporting child care providers, including assistance with starting and operating a child care business, ongoing professional development and training both in person and online classes, and information and support about how to make quality improvements that positively impact the children in their care; and

- Networking with employers and community partners to provide information about family-friendly policies and programs that benefit employees, child care supply and demand data, and how to support the development of high-quality child care programs in their communities.

Ms. Ediger reported since 2007, Child Care Aware of America (formerly NACCRRA) has produced annual rankings of State Standards and Oversight, alternating years for Child Care Centers and Small Family Child Care Homes. She noted Kansas has made incredible progress to ensure all children in child care are safe and well cared for by a trained provider. Her testimony included score and ranking information, which showed the State's improvement from a ranking of 42 in 2008 to a ranking of third in the nation in 2012 in the category of Small Family Child Care Homes. Ms. Ediger reviewed the following strengths identified in the 2012 report:

- All family child care homes caring for one or more unrelated children are required to be licensed;
- All family child care homes are inspected once per year;
- Routine and complaint based inspections are unannounced;

- Child care licensing staff are required to have a bachelor's degree in early childhood education or related field;
- Inspection and complaint reports are available online;
- Providers are required to have comprehensive initial training, including first aid and CPR certification;
- Providers must offer toys and materials in all developmental domains;
- Providers must offer activities addressing all developmental domains;
- Health standards address ten of ten basic standards; and
- Safety standards address ten of ten basic standards.

Ms. Ediger stated the impact on the number of child care providers attending professional development offered by the child care resource and referral agencies has been tremendous. A chart was provided reflecting the increase in professional development events and the number of providers attending from July 2009 through November 2012. A second chart showed professional development events offered from April 2012 through November 2012 to fulfill Lexie's Law requirements and the number of providers attending. She noted since Lexie's Law was passed, training has been provided to just under 9,200 providers.

Ms. Ediger provided the following additional measures, supported by Child Care Aware of America, which she would like to see included:

- Require the use of state and federal fingerprints for checking an individual's criminal history and include a review of the sex offender registry for background checks;

- Increase the initial training requirements for providers from 15 to 40 hours of comprehensive initial training, including CPR and first aid;

- Increase the annual training requirements for providers from 10 to 24 hours, including CPR and first aid; and

- Limit providers to caring for not more than two infants when older children are present.

Several questions were posed by Committee members related to funding sources for the program. Ms. Ediger indicated Child Care Aware of Kansas receives federal grants and funding from DCF, has partnerships with various foundations, and receives membership fees on a voluntary basis with a minimum of $25 (with some members donating $500 per year). She indicated reductions in funding have affected the agency's ability to provide services.

Ms. Ediger reported Child Care Aware has an online presence with 15 hours of professional development. It also offers 120 hours to obtain a Child Development Associate (CDA) credential, and the courses are available in both English and Spanish. CDA renewal courses also are available in both languages, as are multi-lingual staff who can assist with questions.

A copy of the 2012 NACCRRA Report of State Standards and Oversight of Small Family Day Care Homes was provided by Ms. Ediger at the conclusion of her testimony (Attachment 6). She noted Kansas received 111 of the 140 total possible points.

A Committee member commented when Lexie's Law was being proposed, there were a number of opponents and inquired as to what happened with these opponents. Ms. Ediger responded they probably either have accepted the law or are no longer in the child care business.

There were several questions and concerns expressed by Committee members regarding the amount of funding being provided and whether the funding has been adequate to provide the needed services. Ms. Ediger expressed appreciation for the questions and concern. She stated Child Care Aware has received the same level of funding for the past seven years from DCF. The $2.2 million received each year was shared with other resource and referral agencies; Child Care Aware kept only 8 percent of the funds. As a result of not being awarded a contract under a Request for Proposal, Child Care Aware will see an approximately $30,000 funding cut from DCF. Due to a Children's Cabinet decision to spend Children's Initiative Funds on other priorities, Child Care Aware will see a $6 million reduction in grant funding as of December 31, 2012. Beginning in January 2013, Child Care Aware's budget will be cut by nearly two-thirds, and eight permanent staff will be laid off. The budget will go from $10.3 million to about $4 million. Ms. Ediger stated she will continue to work with the Child Care Aware Board of Directors on alternative funding sources.

Ms. Ediger reported Child Care Aware is not involved in the licensing of child care providers. However, the agency has been implementing the Kansas Quality Rating Improvement System (KQRIS) for the past seven years. Ms. Ediger explained DCF has to submit a state plan every two years to the federal government outlining how the Child Care Development Block Grant funds will be used. The last state plan was submitted in August 2012 and included a quality rating system, professional development, and resource and referral. Ms. Ediger stated, though KQRIS is required under this state plan, parts of these state plan requirements are not being funded by DCF. Child Care Aware has obtained support from two foundations to fund KQRIS in one county, and Douglas County Smart Start received funding from the Children's Cabinet for KQRIS. Ms. Ediger said the rating system has been decimated and funding for projects within KQRIS is being discontinued. To illustrate, she stated DCF discontinued funding for the college scholarships through Teacher Education and Compensation Helps (T.E.A.C.H.) Early Childhood Project under KQRIS three years ago; funds also are being discontinued for education-based salary supplements to child care providers and early education staff (Child Care WAGES), which provided a wage bonus to help reduce staff turnover in child care facilities and improved quality of care.

Several Committee members expressed concern about the reductions in funding and the ability of the agencies to provide the required services. The members emphasized the importance for presenters to inform legislators of the funding issues, so they could be addressed. One Committee member noted legislators cannot do their job if they are not informed of funding problems. Several members agreed Lexie's law is a good tool, but it had not been funded to the level required to fully implement it. However, it also was noted due to Lexie's law, far fewer children are at risk because all day care homes now are being inspected.

A Committee member referred to a previous question and asked what opposition had been expressed concerning Lexie's Law when the bill was being considered. The response provided by a couple of Committee members included opponent concerns with government interference in people's lives, the applicability of the bill to family members providing child care services and related questions.

Another Committee question related to the impact of the 10 percent cut in agency budgets requested by the Governor. Ms. Ediger indicated she did not expect another cut over what she had already explained.

A Committee member asked whether child care licensure fees have been raised. Ms. Berroth reported the fees were raised as a result of Lexie's Law, from $10 to $85 for licensed day care homes and from $12 to $87 for group day care homes. The fees are set in statute and the Legislature would need to approve any changes in the fees. A fee fund (funded by licensing application fees from new licenses and renewals) supports inspection and staffing.

Ms. Berroth shared information about the sources of funding for the Bureau of Family Health and stated the Bureau's funding has been fairly well protected from reductions. She agreed to provide more detailed information on funding to staff for Committee members.

Committee members expressed appreciation for all the work the agencies have done to implement Lexie's Law successfully and in a timely manner.

Written testimony was provided by the following individuals:

- Elizabeth Purcell, Parent (Attachment 7)
- Kim Engelman, Ph.D., Lexie's Parent (Attachment 8)
- Terica Gatewood, PharmD., Parent (Attachment 9)
- Lisa Purkey, Parent (Attachment 10)
- Barbara Gulin, Parent (Attachment 11)
- Sonja Mollison, Day Care Provider (Attachment 12)
- Rose Grimes, Day Care Provider (Attachment 13)
- Tammi Hill, Day Care Provider (Attachment 14)
- Sherri Webb, Day Care Provider (Attachment 15)
- Brenda Schoen, Day Care Provider (Attachment 16)
- Diane McAninch, Day Care Provider (Attachment 17)
- Katie Mosher, Day Care Provider (Attachment 18)
- Diane Purcell, Director, Security Benefit Academy (Attachment 19)
- David Wiersma, CIC, State Sales Manager, West Bend Mutual Insurance (Attachment 20)

Vice-chairperson Schmidt suggested the following items be included in the Committee report to the 2013 Legislature:

- A thank you and congratulations to the KDHE staff, especially Rachel Berroth as the Director of the Bureau of Family Health, in recognition of the smooth, seamless, and successful implementation of Lexie's Law;

- Mention of the improvement in Kansas' score from 41st in 2010 to 3rd in the 2012 NACCRRA Report;

- Recognition of the cleanup legislation passed in 2012, which addressed some of the hurdles KDHE was experiencing, with a notation that at the current time KDHE expresses no concerns with the law;

- Inclusion of some of the statistics from the reports provided during the child care presentations to the Committee;

- Mention of the enthusiasm of the presenters and their hard work on the implementation of the rules and regulations; and

- An awareness of the budget cuts some of the child care partners are experiencing and the concern that needed tools and funds be provided.

Vice-chairperson Schmidt asked the Committee to consider other possible recommendations. She reminded Committee members the Committee terminates on July 1, 2013. She also said there is an interest by many for providing KanCare oversight. It was suggested and agreed the Committee report would include a recommendation for legislative committee oversight of KanCare.

The meeting was adjourned.

Thursday, December 20

Vice-chairperson Schmidt called the meeting to order at 9:00 a.m. and welcomed all attendees.

Mark Dugan, Chief of Staff, Lieutenant Governor's Office, began with a summary of items to be discussed, which were identified as areas of interest from the December 6 Committee meeting. These included information on the KanCare Ombudsman, front-end billing, and performance and accountability enhancements.

Secretary Shawn Sullivan, Kansas Department for Aging and Disability Services (KDADS), introduced the new KanCare Ombudsman, James Bart, who was hired on December 12, 2012 (Attachment 21). He explained the Ombudsman will help KanCare consumers to:

- Resolve service-related problems;
- Understand and resolve billing issues/notices of non-coverage; and
- Learn and navigate the grievance and appeal process.

The KanCare Ombudsman also will serve as a point of contact and resource for legislative and other inquiries into the provision of Long-Term Care Services and Supports (LTCSS). Additional responsibilities include advocating for the rights and proper treatment of KanCare consumers. Secretary Sullivan noted the Ombudsman will represent KDADS on consumer councils, focus groups, mediation with consumers, State policy divisions, and KanCare plans. The position will provide counsel to the Secretary and report to the Legislature on an annual basis.

Secretary Sullivan stated the KanCare Ombudsman position was placed under KDADS because of the administrative and legal support that would be available to the position from existing staff. The KDADS Office of the Secretary has nine legal staff who can provide legal research and information. Secretary Sullivan reported a commitment to a response to hotline calls within 48 hours or less. The call volumes and types of calls received will be monitored to determine whether one KanCare Ombudsman will be sufficient to handle the required duties.

Secretary Robert Moser, M.D., KDHE, next provided information concerning front-end billing. He began by expressing his gratitude for the funding provided to start the KanCare Front-End Billing (FEB) solution and to the many stakeholders who have been involved in the process. Secretary Moser stated there was concern about billing for services, and a request was made to the Legislature to continue providing FEB. He noted, as a result of legislative and stakeholder input earlier this year, $1 million was appropriated during the 2012 Legislative Session to implement a KanCare FEB solution. The funds were restricted pending release by the State Finance Council after the approval of the 1115 Demonstration Waiver by the Centers for Medicare and Medicaid Services (CMS). The State Finance Council approved the release of the funding on December 12, 2012.

Secretary Moser stated the FEB solution was developed to aid providers, billing agents, and clearinghouses participating in KanCare. FEB would allow entities to continue submitting UB-304, CMS-1500, and dental KanCare claims directly to the State's fiscal agent, or to submit claims electronically to each Managed Care Organization (MCO). Pharmacy point-of-service claims are excluded from FEB. He reported the FEB service will forward claims the same day to the beneficiary's KanCare MCO.

Kari Bruffett, Director, Division of Health Care Finance, KDHE, next shared information concerning KanCare performance and accountability enhancements. She explained, under Pay for Performance (P4P), three to five percent of total payments to the MCOs are withheld until certain quality thresholds are met. During the first year, three percent is withheld. The thresholds increase yearly to promote continued quality improvement. Ms. Bruffett stated there will be 6 operational outcomes measures in the first year and 15 quality of care measures in the second and third years. She indicated the P4P program places new emphasis on employment rates for people with disabilities, person-centered care in nursing facilities, and resources to community-based care and services.

Ms. Bruffett further explained the first-year operational outcome measures will include timely claims processing (the KanCare contract requires payment within 30 days), encounter data submission, credentialing process in a timely manner using a standardized form, grievances, appeals, and customer service. There will be firm protections with a strong emphasis on data, outcomes, and performance benchmarks. She noted each contractor is required to:

- Maintain a Health Information System (HIS);
- Report data to the State and CMS;
- Submit to an External Quality Review (EQR); and
- Write, and submit for approval, a Quality Assessment and Performance Improvement (QAPI) program.

According to Ms. Bruffett, the goal is to have more transparent and readily available data. The first quarterly report to CMS will be for the first calendar quarter of 2013. The quarterly reports will include:

- Enrollment information, by eligibility group;
- Outreach and innovative activities;
- Operational development and issues;
- Financial, budget neutrality development (the federal government caps KanCare expenditure to an amount equal to or less than the amount the State would have spent on Medicaid without KanCare), and related issues;
- Member month reporting, by eligibility group;

- Consumer issues;
- Quality assurance and monitoring activity;
- Managed care reporting requirements (network adequacy, customer service, appeals process, grievances, and Ombudsman activities);
- Safety net care pool; and
- Demonstration evaluation (design and planning) by an independent third party.

Ms. Bruffett provided a comparison of the performance measurements for the existing Medicaid program and the new KanCare program (Attachment 22). She stated both programs included the following measures: Healthcare Effectiveness Data and Information Set (HEDIS); Consumer Assessment of Healthcare Providers and Systems (CAHPS); Performance Improvement Projects (PIP); and HCBS Waiver performance measures. However, KanCare includes six additional items in its year one P4P Initiative and an additional 15 items in years two and three. She noted the frequency of measurements has been heightened to quarterly and monthly where applicable.

A copy of the KanCare Managed Care Organization Network Access report (as of December 10, 2012) was provided by Ms. Bruffett (Attachment 23). She indicated KanCare participation by 100 percent of the current Medicaid providers had not been reached, but the expectation is MCOs will continue efforts to expand the network.

Next, Ms. Bruffett discussed continuity of care in KanCare (Attachment 24), which included the safeguards for consumers. The State wants to preserve continuity of care for members who have appointments and established relationships with providers prior to January 1, 2013. For all KanCare members, the three MCOs must honor all plans of care, prior authorizations, and established provider-member relationships during the transition to KanCare. Even if an established provider is not in an MCO's network, the provider still will be paid at 100 percent of the Medicaid fee-for-service (FFS) rate through the first 90 days.

Ms. Bruffett explained services provided to KanCare members currently living in a Medicaid-reimbursed residential setting, such as a nursing facility, will be paid by the MCOs to the facilities at the Medicaid FFS rate for one year, even if the provider is not in the MCO's network.

Further, Ms. Bruffett noted individuals receiving Home and Community Based Services (HCBS) through one of the HCBS waivers will be provided services up to an additional 90 days under existing plans of care and current providers if a new plan of care is not in place within 90 days of January 1, 2013. This would give HCBS members up to 180 days from KanCare implementation to continue with their existing services and providers, regardless of whether the providers are in an MCO's network.

KanCare members were pre-assigned to one of the three MCOs in November 2012. However, Ms. Bruffett explained, the members will have the rest of 2012 and 90 days after January 1, 2013 (until April 4, 2013) to choose the plan they prefer.

Ms. Bruffett stated the three KanCare MCOs must ensure specialty care is available to all members. The MCOs are required to meet federal and state distance or travel time standards. Members must be allowed to see out-of-network providers if an MCO does not have a specialist available to members within those standards. Ms. Bruffett explained, if a KanCare MCO is unable to provide medically necessary services in its network, it must cover those

services out of network. Further, MCOs must have single-case arrangements or agreements with non-network providers ensure members have access to covered services. She also noted the payment rate will be negotiated between the plan and the non-network provider, and these providers cannot bill members for any difference.

According to Ms. Bruffett, emergency services under KanCare are not limited to in-network hospitals. As required by federal law, the State's KanCare contract requires each MCO to cover and pay for emergency services, including services needed to evaluate or stabilize an emergency medical condition, regardless of whether the provider that furnishes the service has a contract with the MCO.

For other out-of-network services after the transition, Ms. Bruffett noted the State KanCare contract allows MCOs to pay out-of-network providers that choose to provide services to Medicaid members 90 percent of the Medicaid rate. Under federal law, the Medicaid member cannot be made to pay the balance between the standard rates and those paid by the MCO.

Ms. Bruffett stated she will provide the Committee with the latest HCBS network access report, which is formatted on a by-county basis. The report was not provided to the Committee at the meeting because the update was received the night before. A change from the report previously provided to the Committee resulted from conversations with CMS clarifying a requirement that two providers must be available in each county, but that could include two individuals working for one agency. As such, the earlier report was under-counted. Ms. Bruffett noted the Geo Access report is available on the KanCare website on the "readiness activity page" under "network."

Following the conclusion of Ms. Bruffett's presentation, time was allotted to answer Committee questions. One Committee member asked if there were any outstanding issues with the providers concerning the status of their contracts. Ms. Bruffett said there are still ongoing negotiations between the MCOs and various providers, but significant progress has been made. She noted this is one reason for the 90-day transition period. Ms. Bruffett stated there is no guarantee all MCOs will be able to contract with all existing Medicaid providers, because providers cannot be forced to participate. However, she indicated providers are entering KanCare in good faith.

Another Committee member asked for assistance in understanding the algorithm for the auto-assign process and how that has evolved. Ms. Bruffett spoke in general terms and said the goal was to match an individual with an MCO that has the individual's main provider in the network. For a majority of individuals, the algorithm first looks for the network in which their primary physician is located. The next goal is to keep all members of the same household in the same plan. Next, risk and morbidity factors also are taken into consideration when making provider assignments. For individuals in nursing facilities, she indicated the first consideration was whether the facility was in the network; then consideration was given to continuity of care. According to Ms. Bruffett, assignments differed by HCBS waiver, and program managers closely assisted in evaluating which providers would best meet the needs of the individual. For HCBS waiver services, the algorithm first looked at the residential provider, then continuity of care, and risk distribution. Risk was assessed using the Johns Hopkins tool. Those applying for Medicaid will have an opportunity to choose a plan at the time of application. If a plan is not selected, then the individual will be assigned using this process.

As a follow-up question, a Committee member asked whether the MCOs are guaranteed a minimum level of enrollees, and Ms. Bruffett indicated such was not the case.

A Committee member inquired whether all of the physicians who work for a hospital that has contracted with an MCO also are included in the contract. Ms. Bruffett responded that would depend on how the hospital contracts with its physicians.

There was a Committee question as to current plans for a KanCare oversight committee and whether the legislation to be considered mimicked the plan previously considered during the 2012 Legislative Session. Mr. Dugan indicated he believed the bill reviewed by the Joint Committee on Home and Community Based Services Oversight is very similar to the bill passed out of the Senate during the past session.

A Committee member inquired as to the progress of the Kansas Eligibility and Enforcement System (KEES) project and the savings projections. In addition, a request was made concerning a report on the scope of the project, its accomplishments, and the milestones it hopes to attain. Dr. Moser indicated he would provide the information to the Committee.

There was an inquiry as to the use of the KEES online system instead of paper applications for KanCare. Dr. Moser expressed his preference for use of the online system and noted there are a number of locations available for those individuals without computer resources to input their information.

There was some discussion about the Administration's position on the implementation of a health insurance exchange in the State. There also was a question concerning whether the State would look at a health insurance exchange model similar the one Utah is considering. Mr. Dugan indicated Utah is considering a very different model, more of an open marketplace, but the Administration will monitor what occurs with Utah and other states.

Another question raised the issue of what will happen if Medicare rates are reduced after January 1, 2013, without some action from Congress. Ms. Bruffett indicated the rates are based on current Medicare rates, and there are no plans to change; however, adjustments may need to be made if the rates are reduced. She also mentioned the primary care physician rate bump the State already has submitted to CMS, which would raise the rate paid to primary care physicians providing Medicaid services to 100 percent of Medicare.

There were several questions concerning the appropriateness of the KanCare Ombudsman position being located under KDADS, and how the Ombudsman would be able to maintain autonomy. Secretary Sullivan stated he would like to monitor the situation for a couple months and then evaluate whether a change should be made. He stated he believes the level of support staff available to the Ombudsman from the KDADS staff will be very beneficial at this point in the process. The new Ombudsman, James Bart, introduced himself and relayed the convenience of having the KDADS staff readily available. He also shared his personal and work background, including both a business and a law degree and his advocacy for a son with autism.

A Committee member inquired about a single point of entry for legislators with constituent questions and concerns regarding KanCare. Mr. Dugan indicated he or Ren Mullinix are the contact persons in the Lieutenant Governor's Office. Questions would be forwarded to the appropriate agencies, as indicated by the nature of the request.

A question arose as to whether additional administrative staff, who might need to be added depending on the volume of calls to the KanCare Ombudsman, would respond to Mr. Bart or to Secretary Sullivan. Secretary Sullivan indicated he sees the current administrative support personnel as intake specialists who would not be used for the purpose of addressing

problem solving and grievance procedures. If the calls required an advocacy or mediation role, additional resources would need to be brought in to assist. He noted the support staff assisting with answering telephone calls are in the Office of the Secretary and would not answer to Mr. Bart.

There also were some questions and comments concerning the expansion of Medicaid and how the State might address the issue of uninsured persons. Mr. Dugan commented the Administration is continuing to study the issue and examine the latest federal administration requirements concerning 100 percent reimbursement based on certain poverty levels. He indicated, since the last Committee meeting, the federal government has declared states will be eligible for 100 percent Medicaid reimbursement only if they expand Medicaid to 133 percent of the federal poverty level and not for Medicaid expansion to a lower federal poverty level. He also noted, regardless of Medicaid expansion, the need to address the issues of the uninsured and underinsured continues. Mr. Dugan expressed an interest in working closely with the Legislature to examine suggestions for solutions to these issues. He noted the State did not cut Medicaid by ten percent and instead took a long-term approach. He stated any changes must be examined for their long-term ramifications on the total budget of the State. Mr. Dugan also stated the Administration currently is looking at Medicaid expansion cost studies completed by several entities and is preparing its own cost analysis.

Vice-chairperson Schmidt expressed her gratitude to everyone for their time and attendance. She also recognized Dr. Kelley Melton, Pharmacist, for her work in helping the pharmacy community navigate KanCare through the decisions that have needed to be made and with keeping pharmacists up to date on the program.

Vice-chairperson Schmidt notified members the minutes for December's three Committee meetings will be distributed *via* e-mail for their comments and approval. She also requested input concerning information to be included in the Committee report. One Committee member noted the importance of providing education concerning KanCare to the entire legislative body, particularly considering the number of new members in 2013. Secretary Sullivan reported a letter with summary information concerning KanCare soon will be distributed to the legislative members, and an educational summit for legislators will be held on January 16 at Memorial Hall.

Vice-chairperson Schmidt next referred members to a memorandum prepared by the Kansas Legislative Research Department outlining preliminary recommendations for inclusion in the Committee report to the 2013 Legislature, as discussed at yesterday's Committee meeting (Attachment 25). It was noted the Joint Committee on Health Policy Oversight will terminate on July 1, 2013. A recommendation was offered that the Committee terminate only if a substitute oversight committee is established, and that the Committee support legislation creating a committee to oversee KanCare.

The meeting adjourned at 10:30 a.m.

Prepared by Debbie Bartuccio
Edited by Iraida Orr

Approved by Committee on:

January 22, 2013
(Date)