PERFORMANCE AUDIT REPORT

Health-Care Related Services: Reviewing Options for Better Coordinating the State's Health-Care Related Programs

A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
January 2011

10PA19

Legislative Post Audit Committee
Legislative Division of Post Audit

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January 24, 2011

To: Members, Legislative Post Audit Committee

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This report contains the findings, conclusions, and recommendations from our completed performance audit, *Health-Care Related Services: Reviewing Options for Better Coordinating the State's Health-Care Related Programs*.

The report also contains appendices showing State-Administered Health-Care and Long-Term Care programs and resources for more information on Federal Health Care Reform.

The report includes recommendations for the Governor, the Health Policy Authority, the Department of Health and Environment, the Department of Corrections, the Department of Social and Rehabilitation Services, and the Juvenile Justice Authority. We would be happy to discuss these recommendations or any other items in the report with any legislative committees, individual legislators, or other State officials.

We would be happy to discuss the findings presented in this report with any legislative committees, individual legislators, or other State officials.

Scott Frank
Legislative Post Auditor

READER'S GUIDE

The Big Picture

Audit Highlights	The highlights sheet, inserted in each report, provides an overview of the audit's key findings
Conclusions and Recommendations	Located at the end of the audit questions, or at the end of the report
Agency Response	Included as the last Appendix in the report
Table of Contents, and lists of figures and appendices	Lets the reader quickly locate key parts of the report

The Details

"At-a-Glance Box"	Used to describe key aspects of the audited agency; generally appears in the first few pages of the main report
Side Headings	Point out key issues and findings
Charts, Tables, and Graphs	Visually help tell the story of what we found
Narrative Text Boxes	Highlight interesting information or provide detailed examples

This audit was conducted by Laurel Murdie, Katrin Osterhaus, and Ivan Williams. Joe Lawhon was the audit manager. If you need any additional information about the audit's findings, please contact Laurel Murdie at the Division's offices.

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Health-Care Related Services: Reviewing Options for Better Coordinating the State's Health Care Related Programs

A 2007 Legislative Post Audit identif ed seven State agencies that play some role in providing health-care related services to Kansans. Those agencies are the Department of Social and Rehabilitation Services, the Kansas Health Policy Authority, the Department on Aging, the Department of Health and Environment, the Commission on Veterans Affairs, the Department of Corrections, and the Juvenile Justice Authority.

Among the services those agencies provide are medical and long-term care services, medical insurance for the f nancially disadvantaged, preventive health services through local health departments, and care and counseling for veterans, the elderly, developmentally disabled, and mentally ill.

Recently, legislators have raised questions about whether the delivery system for health-care related services in Kansas could be revamped to reduce costs, eliminate service gaps, and improve coordination, accountability, and eff ciency.

This performance audit answers the following questions:

1. **Could costs be reduced or services offered more effectively by better coordinating the health-care related services provided by State agencies?**

2. **How will federal health care reform affect Kansas' health-care related programs?**

A copy of the scope statement the Legislative Post Audit Committee approved is included in ***Appendix A***. We added the second question to address stakeholders' and legislators' concerns about the recently passed federal health care reform provisions.

To answer these questions, we interviewed off cials from all seven State agencies, as well as off cials from numerous Kansas health care associations, advocacy groups, and foundations to learn about potential duplication, service gaps or coordination issues. We evaluated a number of issues they mentioned by interviewing appropriate State or local government off cials, and by reviewing relevant documents.

In addition, we reviewed a number of summary reports on federal health care reform to understand its general goals and major components. We also evaluated a number of duplication, service gap, or coordination issues to determine whether they likely would improve or worsen with upcoming reform changes. Finally, we interviewed a number of State agency officials about their roles and responsibilities, as well as their accomplishments to date, on implementing various components of federal health care reform.

We conducted this performance audit in accordance with generally accepted government auditing standards, except that, because of time constraints, we didn't test certain inmate medical cost data we received from the Department of Corrections' contractor. The data were used to estimate potential Medicaid savings. The standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. Although we didn't test this data, it is unlikely that it's so grossly or systematically wrong as to affect our findings and conclusions. Still, the reader should consider the savings estimates related to inmate inpatient care as a reasonable estimate, not as absolute fact. Overall, we believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Our findings begin on page 7, following a brief overview.

Overview of Health-Care Related Services in Kansas

Several State Agencies Manage Kansas' Health-Care Related Programs

In 2007, we developed an inventory of Kansas' government-funded health-care related programs. That report highlighted the myriad of agencies and programs involved in providing health-care related services in Kansas. As of 2010, it appears that generally, the same agencies and programs are in place.

At the time we completed the 2007 audit, State and Federal expenditures for the programs were about $2.5 billion for f scal year 2006. For this audit, we didn't update the cost information shown in the 2007 audit because it would have required us to complete that audit work again—which we couldn't do within the time allowed for this audit. In addition, federal health care reform likely will signif cantly change the State and federal expenditures in the coming years. We discuss health care reform more fully in Question 2.

Kansas currently has seven State agencies with major health-care related responsibilities. ***Figure OV-1*** on the next page summarizes the agencies' missions and their health-care related program responsibilities.

As the f gure shows, the three agencies with the largest health care programs (in terms of spending) are the Kansas Health Policy Authority, SRS, and the Department on Aging. In contrast, the Department of Corrections, Juvenile Justice Authority, and the Kansas Commission on Veterans Affairs manage much smaller health-care related programs. Lastly, KDHE promotes public health, which includes a focus on prevention-related programs.

Because the Health Policy Authority is a fairly new agency, a couple of things to note:

- **The Health Policy Authority recently was created to manage certain health-care related programs.** The 2005 Legislature created the Health Policy Authority as an independent State agency within the executive branch, and it's overseen by a 16-member Board. By fiscal year 2007, the agency was responsible for several medical assistance and other programs previously managed by SRS, and the Health Care Data Governing Board.

Figure OV-1
Seven Kansas Agencies Providing
Health-Care And Long-Term Care Programs

Agency / Mission / Major Health-Care Related Programs	FY 2006 Cost (State & Federal) (a)
Kansas Health Policy Authority (KHPA): To develop and maintain a coordinated health policy agenda that combines effective purchasing and administration of health care with promotion-oriented public health strategies. • Medicaid Health Insurance Program • Children's Health Insurance Program • State Employee Health Plan	$1.2 billion
Department of Social and Rehabilitation Services (SRS): To protect children and promote adult self-sufficiency. • Mental Health and Substance Abuse Programs • Developmental Disability Programs-Mental Retardation and Physical Disability Home & Community-Based Services (HCBS)	$731 million
Department on Aging: To promote the security, dignity and independence of Kansas' seniors. • Inpatient-Based Nursing Facilities Program • Frail Elderly Home & Community-Based Services (HCBS)	$393 million
Kansas Department of Corrections (KDOC): To protect the public by providing reasonable, safe, secure, and humane control of felony offenders. • Medical and mental health services for Inmates • Chemical Dependency Recovery Program	$40 million
Kansas Department of Health and Environment (KDHE): To promote and protect the health of Kansans through public health programs and services and through preservation, protection, and remediation of natural resources in the environment. • Infants and Toddlers with Disabilities Program • Disease Prevention and Health Promotion • Immunization Program • Maternal and Child Health Services	$34 million
Juvenile Justice Authority (JJA): To promote public safety by reducing juvenile crime in Kansas and developing a balanced juvenile justice system. • Medical and mental health services for juvenile offenders	$25 million
Kansas Commission on Veterans' Affairs (KVCA): To serve Kansas veterans and their families, relatives, and dependents with dignity and compassion and to be their principal advocate in ensuring they receive information advice, direction, medical care, benefits, social support and lasting memorials in recognition of their service to Kansas and to the nation. • Kansas Veteran's Home care for veterans and dependents • Soldier's Home care for veterans and dependents	$15 million
Total:	$2.5 billion

(a) We reported FY 2006 costs because there is no readily available up-to-date source for State and Federal health-care costs by program.

Sources: Budget Analysis FY 2011; *Health-Care Related Programs in Kansas: Determining What Funding Kansas Receives and Who Administers It,* 07PA18; and interviews with agency officials.

- **Although the Health Policy Authority is the designated Medicaid agency for the State, several other agencies have Medicaid-related responsibilities.** Medicaid is a joint federal and state program that provides health and long-term care services to people with low incomes. The federal government requires each state to have a designated agency to act as the main contact and billing agent. In Kansas, the Health Policy Authority fulfills that role.

  As ***Figure OV-1*** shows, the Health Policy Authority currently is responsible for the programming and purchasing of regular health (medical) services for the Medicaid program. Other agencies are involved with Medicaid as well. SRS maintains programming responsibilities over the State's mental health and substance abuse portions of Medicaid, as well as certain waiver programs the State created as part of its Medicaid plan. The Department on Aging is responsible for administering long-term care services for the elderly covered by Medicaid. Finally, the Juvenile Justice Authority has a minor role in billing Medicaid services for some of its adjudicated youth.

Currently, these seven State agencies manage 55 different health-care related programs. Four agencies—the Health Policy Authority, KDHE, SRS, and the Department on Aging—are responsible for most (48 of 55) programs. Some of the programs are very large, such as the Medicaid-paid regular medical services managed by the Health Policy Authority or the long-term care nursing facility program within the Department on Aging. Other programs are much smaller, such as the Childhood Lead Poisoning Prevention Program within KDHE.

Appendix B provides a listing of all 55 health-care related programs we identif ed.

Question 1: Could Costs Be Reduced or Services Offered More Effectively by Better Coordinating Health-Care Related Services Provided by State

Answer In Brief:

Changing Medicaid billing practices could save the State money, especially as it relates to inpatient care provided to Department of Correction's inmates. In addition, several smaller opportunities exist for State agencies to better coordinate other health-care related programs, including inmate releases from Larned State Hospital and the State's two contracts for mental health services. We also found other, much larger problems which are primarily broad service gap issues that can only be addressed through State-level policy decisions. They include the lack of affordable health insurance for low-income single adults, a shortage of medical providers in some parts of the State, significant backlogs in processing Medicaid applications, and the overall fragmentation of medical services. These and related findings are discussed in the sections that follow.

For this audit we determined whether programs could be better coordinated, whether services were duplicated, or whether they were lacking. To do that, we updated the program information from our 2007 audit (which was simply an inventory), and reviewed the information to determine whether similar services were provided to similar populations. We also interviewed off cials from a number of State agencies, health care associations, advocacy groups, and foundations about their knowledge of service duplication or gaps, or coordination issues.

Our work didn't uncover obvious duplication problems, but we did f nd opportunities for cost savings, better coordination, and a number of service gap issues. The remainder of this question describes our f ndings in those areas.

Changing Medicaid Billing Practices Could Save Up to $473,000 Annually And Could Result in More Savings Starting in 2014

As described in the Overview, Medicaid is a joint federal and state program that provides health and long-term care services to people with low incomes. In general, the federal government covers 60% of the expenditures and the State is responsible for the remainder.

Kansas could realize significant savings each year by billing Medicaid for some inpatient care provided to inmates. While they may have low incomes, inmates typically aren't eligible for the Program regardless of their income status. This means the State pays the full cost of health care for them.

However, Medicaid can be billed for medical services for inmates when they are hospitalized outside a correctional facility. Essentially, hospitalized inmates are "temporarily" eligible for Medicaid and a recent performance audit in North Carolina showed that by billing Medicaid for their services, signif cant savings are possible. That's because the federal government picks up about two-thirds of the costs. Over the next few years, Kansas could realize signif cant savings as follows:

- **Kansas could save about $473,000 each year by billing Medicaid for some inpatient care provided to inmates**. Kansas currently has about 30 inmates whose inpatient services could be billed to Medicaid. If Medicaid had been billed for those services provided during fiscal year 2010, we estimated the gross savings for the State would have been about $473,000 a year.

  The Department of Corrections would have to renegotiate with its contractor for the State to realize these savings. Officials with the contractor told us they would be willing to do so.

- **Under federal health care reform, more people will be eligible for Medicaid starting in 2014, which increases the potential savings**. Using 2010 inmate data and current Medicaid rates, we estimate that Kansas would be able to save almost $2.8 million a year.

  The Health Policy Authority and the Department of Corrections would need to coordinate how to quickly determine whether a hospitalized inmate is Medicaid-eligible. Because the Health Policy Authority currently is procuring a new computer system, the State would likely incur some minimal one-time costs to automate and implement these changes and the costs would be recovered quickly.

Department of Corrections off cials cautioned that billing at the lower Medicaid rates could result in some hospitals simply refusing to provide care. In addition, they said savings potentially could be offset by higher costs to transport inmates to facilities that will accept Medicaid payment. The reader should be aware that in developing these estimates we didn't test the data provided by the contractor.

Eliminating a small amount of Medicaid billing at the Juvenile Justice Authority could increase efficiencies. The Health Policy Authority contracts with Hewlett Packard to process Medicaid-related bills from hospitals, doctors, and other medical providers. As noted in the Overview, Kansas has multiple agencies involved with Medicaid services. Each agency must work with Hewlett Packard and the Health Policy Authority to make sure Medicaid expenditures are properly recorded in their individual budgets.

Although this process may make sense for agencies dealing with a large number of Medicaid claims—such as the Health Policy Authority, SRS, and the Department on Aging—it may not be reasonable for agencies handling only a few claims to develop and maintain Medicaid billing expertise. According to Juvenile Justice Authority off cials, several staff are involved in processing claims for about 70 juvenile offenders in psychiatric residential treatment facilities. Eliminating these tasks wouldn't free up enough time to eliminate a position, but staff could use the time to focus on other tasks.

SRS off cials suggested they could possibly absorb the Medicaid billing responsibility for the Juvenile Justice Authority, because the agency already has oversight responsibility over these psychiatric residential treatment facilities, and is experienced in processing Medicaid claims.

There Are Several Opportunities For State Agencies To Better Coordinate Health Care Programs

With a number of State agencies involved in providing health-care related programs, it's important for agencies to coordinate so that multiple agencies aren't offering similar services. In addition, coordination can help agencies streamline work processes and can improve individual programs. In reviewing a number of concerns raised by stakeholders, we found problems with coordination in the following three areas:

- Sharing data related to the Women, Infants and Children program
- Coordinating inmate releases from Larned State Hospital
- Coordinating Mental Health Services contracts

These issues are detailed in the sections that follow.

The Health Policy Authority and KDHE could share data to ensure that consumers eligible for the Women, Infants and Children (WIC) program receive those benefits. Pregnant women, infants, and young children enrolled in the Medicaid program automatically meet income eligibility requirements of the WIC program, which provides supplemental food assistance and nutrition education. At the State level, the program is managed by KDHE, while Medicaid is managed by the Health Policy Authority.

Currently, KDHE and KHPA staff can't tell how many Medicaid-eligible consumers also could be eligible for federally funded WIC benef ts. As a result, eligible people may not be receiving this nutritional assistance. Health Policy Authority off cials told us they

can't share Medicaid-eligibility data with the off cials managing the WIC program. However, Authority off cials said that if WIC data were provided to them, they could compare Medicaid and WIC eligible lists to identify the Medicaid recipients who aren't enrolled in the program and then notify WIC-eligible families by mail.

KDHE off cials agreed this type of coordination could work, and that WIC outreach funding could be used to pay for expenses associated with sending out eligibility notices.

The Department of Corrections and SRS could better coordinate inmate releases from the Isaac Ray unit at Larned State Hospital. SRS manages the 90-bed unit which is used to house inmates with chronic psychiatric symptoms. Although there's a memorandum of agreement that is supposed to help coordinate inmate discharge planning, in talking with off cials from both agencies, we found the agencies' current practices aren't ref ected in that agreement.

For example, the agreement lists SRS as the agency responsible for all discharge planning, which includes such duties as setting up appointments with community mental health providers. But the Department of Corrections, as part of the release process, has chosen to have its medical staff f ll inmates' prescriptions that were prescribed by the hospital. Corrections off cials told us they f ll the prescriptions because inmates often can't afford the medication themselves, and that without the medication inmates may be more likely to commit another crime.

Corrections off cials also claimed that, due to privacy concerns, SRS doesn't share crucial post-discharge appointment information that parole off cers need to help with inmates' successful reintegration into the community. We couldn't determine whether the information had or hadn't been shared with the Department of Corrections. Regardless, the agencies' current practices for discharging inmates aren't as well-coordinated as they could be.

SRS and the Health Policy Authority could coordinate their contracts for mental health services, which potentially could result in savings. The Health Policy Authority is responsible for mental health services offered as part of the Children's Health Insurance Program, while SRS is responsible for the mental health service portion under the Medicaid program. Each agency has negotiated its own managed care contract for mental health services, as shown in ***Figure 1-1*** on the next page.

Coordinating the two contracts could have the following benef ts:

- Reduced costs associated with bidding, negotiating, and awarding the contracts (currently, staff from both agencies and the Division of Purchases invest time and effort in this process).

- Reduced service costs because the State potentially could negotiate better cost rates by purchasing mental health services for a larger group of people.

- A combined mental health services contract would be more likely to ensure access to a uniform provider network. A small portion of families receive coverage through both contracts because some family members qualify for services through one program and some members qualify under the other. A single coordinated contract should eliminate the confusion these families currently experience.

Off cials from both agencies agreed to look into coordinating the two contracts. However, Health Policy Authority off cials pointed out that its current risk-based contract fulf lls the statutory requirement for a capitated managed care plan. As shown below in ***Figure 1-1,*** SRS's contract is not risk-based. This issue will need to be addressed before the agencies can coordinate.

While stakeholders pointed out a number of other problems related to coordination, we didn't find those concerns to be valid. We heard concerns in several areas and followed up on those that seemed most promising. Our work didn't detect obvious problems in several areas, as described below.

- Consolidation of State hospital laboratories likely wouldn't increase efficiencies. Further, such a move could increase costs because of the large physical distance between the two mental health hospitals that still operate their own labs.

Figure 1-1
Summary of Kansas' Two Mental Health Services Contracts

	SRS (managing Medicaid-paid mental health services) (a)	**KHPA** (managing mental health services for the Children's Health Insurance Program)
Contractor	Kansas Health Solutions	Cenpatico
Type of Contract/ Payment basis	Non-risk Prepaid Mental Health Plan. The contractor is paid an administrative fee and gets reimbursed for each service that members use, thus carrying little risk of incurring a financial loss.	Risk-based Prepaid Health Plan. The contractor is paid a flat cost per member per month, thus carrying the risk of financial loss with increases in services used.
Duration of Contract	July 1, 2007 through June 30, 2009, with 3 individual year optional extensions (Ends June 30, 2012)	May 1, 2006 through June 30, 2008, with 5 individual year optional extensions (Ends June 30, 2012)

(a) SRS also includes the State's MediKan Program in its Medicaid contract for mental health services
Source: LPA review of applicable contract information and interviews with State officials

- The federal Vaccines for Children program appears to be well coordinated between KDHE and the Health Policy Authority, which reduces the State's costs for vaccines.

- The Health Policy Authority has taken steps to try to ensure that a new recovery audit function—meant to reduce incorrect or fraudulent medical or pharmacy claims—won't duplicate the State's existing audit efforts already in place.

Other Problems We Found—Broad Service Gap Issues—Can Only Be Addressed Through State-Level Policy Decisions

In general, our discussions with State agency off cials, health care associations, advocacy groups, and foundations yielded few, if any, specif c service gaps. One exception to that is the lack of Medicaid-paid comprehensive dental services for adults. Kansas, like many other states, doesn't offer this optional benef t.

However, our discussions uncovered some broader service gap issues that likely can't be solved through improved coordination among State agencies. These broad service gap issues likely can only be remedied through State-level policy changes. In addition, federal health care reform potentially could affect these issues signif cantly. Here's a summary of those issues:

- **It's difficult for low-income, single adults to get affordable health insurance coverage.** Kansas offers health coverage for qualifying children, pregnant women, parents, caregivers, seniors, and disabled individuals through the State Medicaid Plan and Children's Health Insurance Program. Federal Medicaid rules currently don't require states to provide Medicaid coverage for low-income, single adults. Kansas, like many other states, has opted not to extend Medicaid eligibility to this population because of the associated costs.

- **Medical providers are scarce in some areas and many providers aren't willing to accept Medicaid payments.** The federal Health Resources and Services Administration designates health professional shortage areas for primary medical care, dental, and mental health providers based on geographic, demographic, or institutional factors. As of 2008, 12% of Kansans live in areas with primary care shortages. This is slightly worse than the national average. Overall, 36% of Kansans live in areas with mental health service shortages, and 19% live in areas with dental health care service shortages. These rates exceed the national average.

  In addition, it's generally known that many practicing doctors won't accept Medicaid because the reimbursement rates are considered too low. This makes it even more difficult for Medicaid recipients to get medical care.

- **A significant backlog in processing Medicaid and children's health insurance applications has delayed insurance coverage for low-income families**. As of November 2010, nearly 16,000 applications for these programs were pending more than 45 days. While waiting for eligibility determination, families may not seek needed medical care for fear of not being able to pay for the services. More information about the backlog is in the box on the next page.

Health Policy Authority officials have said they'll be able remedy the backlog by March 2011 by streamlining the process and using a federal bonus payment to hire more staff. However, once those moneys run out, new backlogs could emerge. As a result, policy makers will need to decide what funding efforts are necessary to prevent future backlogs.

- **Services such as lab work and x-rays often are duplicated because the medical system generally is fragmented.** Stakeholders explained that medical care providers sometimes have problems finding out what tests or procedures the patient has already had. Further, it takes too much time and effort to get the results from another provider. Coordinating care is a bigger problem for low-income, transient individuals because they have a less stable provider network. Potentially, these issues could be remedied through the increased use of Health Information Technology—an initiative that is managed by KDHE. We discuss that initiative more in Question 2.

The conclusion and recommendations for the audit can be found at the end of Question 2.

Information about the State's Backlog of HealthWave Applications

Background:
The Kansas Health Policy Authority administers the Medicaid and Children's Health Insurance Programs, jointly known as HealthWave in Kansas. Under federal rules, individuals applying for Medicaid generally must be determined to be eligible within 45 days of receiving the application. A contractor processes the applications for the Health Policy Authority.

Problem:
In May 2009, the Health Policy Authority warned legislators about a beginning backlog. At that time, about 2,000 applications were pending. In April 2010, the federal Centers for Medicaid and Medicaid Services (CMS) warned the agency to address the issue when backlogged applications surpassed 14,000. Nevertheless, pending applications reached nearly 20,000 in September 2010, according to agency reports.

Cause:
Several factors contributed to the increase in backlogged applications: First, the number of applications increased significantly due to the State's economic crisis and because the Legislature relaxed eligibility requirements for the Children's Health Insurance Program. Second, new federal requirements to verify citizenship made processing applications even more burdensome and time consuming. Third, the Health Policy Authority contracts with an entity to act as a clearinghouse for applications. Shortly after the Health Policy Authority hired a new clearinghouse company, November 2009 budget cuts reduced the new contractors' resources by nearly $1 million.

The Kansas Health Policy Authority's solution:
In August 2010, the Health Policy Authority received a $1.2 million bonus payment from the federal government. The bonus was received for the Children's Health Insurance Program. The agency used about $800,000 to provide additional staff and streamline and somewhat automate the eligibility process. In October of 2010, the agency imposed penalties on the contractor, forcing it to add 23 additional staff to address the backlog. Health Policy Authority officials have informed the Legislature that the backlog will be eliminated by March 2011. As a long-term solution, the Health Policy Authority is currently working on implementing a new eligibility system to replace the largely paper-based system in effect today. The new computer system is expected to handle the expected influx of applications brought about by federal health care reform in 2014.

Question 2: How Will Federal Health Care Reform Affect Kansas' Health-Care Related Programs?

Answer In Brief:	*Federal health care reform will greatly affect how health-care related services are provided in Kansas. The major provisions of reform are focused on reducing the number of uninsured people, slowing increases in health care costs, and increasing the accessibility of essential health care services. Implementing its various components will require significant coordination among State agencies in a number of areas. Finally, although Kansas is taking steps to implement health care reform, it's too early to know whether the State is on track. These and related findings are discussed in the sections that follow.*

Federal Health Care Reform Will Greatly Affect How Health-Care Related Services Are Provided in Kansas

In March 2010, the President of the United States signed a comprehensive health care reform bill, known as the "Patient Protection and Affordability Care Act." (Throughout this report we'll refer to the Act as "federal health care reform.") The major provisions of federal health care reform are intended to do the following:

- **Reduce the number of people without health insurance** by making it easier to qualify for Medicaid and by providing subsidies to make private insurance more affordable.
- **Slow the increase in health care costs** by focusing on prevention efforts and by reducing fraud, waste, and abuse.
- **Increase accessibility of essential health care services** by eliminating restrictive insurance practices and expanding the number of providers and safety net clinics.

We discuss each of these areas in more detail in the following sections.

A main goal of federal health care reform is to <u>reduce the number of people without health insurance</u>. Here are the major components intended to do that:

- **Expanding Medicaid coverage to include low-income adults without children**. Currently, most low-income, childless adults aren't eligible for Medicaid. Under federal health care reform, Medicaid coverage will be expanded to include all adults with income less than 133% of the federal poverty level. Initially, the federal government will pay 100% of Medicaid costs for newly eligible adults. By 2020, the federal share will decrease to 90% of the costs for this group.

- **Increasing federal funding for the Children's Health Insurance Program (CHIP).** Currently in Kansas, 72% of this program's cost is federally funded. Beginning in October 2015, the federal share will increase to 95%. Because this program provides insurance on a first come, first served basis, the increased funding will allow the program to serve more people.

- **Offering health insurance subsidies to help individuals and small businesses purchase affordable health care coverage**. To help create organized and competitive health insurance markets, federal health care reform includes private health insurance "exchanges." For individuals earning less than 400% of the federal poverty level, plans offered through the exchanges will include federal subsidies to help pay for coverage. In addition, starting in 2010, small businesses that pay an average wage of less than $50,000 and that pay at least 50% of their employees' insurance premiums will be able to receive federal tax credits.

- **Imposing tax penalties for employers and individuals in an effort to increase health insurance coverage**. Starting in 2014, large employers who fail to offer minimum coverage or who offer such limited coverage that employees chose publicly subsidized insurance will be subject to a penalty of $2,000 to $3,000 per employee. Finally, in 2014 tax penalties will be imposed on individuals who don't carry health insurance. Requiring individuals to purchase health insurance is considered the most controversial provision of the health care reform.

As ***Figure 2-1*** on the next page shows, federal health care reform will increase publicly funded or subsidized health insurance coverage to those earning less than 400% of the federal poverty level. The Congressional Budget Off ce estimates that reform will provide coverage to an additional 32 million individuals nationwide when fully implemented in 2019.

Another goal of federal health care reform is to slow the increase in health care costs. As described in a June 2010 Congressional Research Service report, health care reform was partly driven by concerns about the unsustainable growth in spending on health care and health insurance, particularly in the Medicaid and Medicare programs. The components of health care reform that are intended to slow the increase in health care costs are summarized below.

- **Requiring health insurance for everyone**. Generally, larger participation within any given insurance pool means the risk of insurance claims can be spread, leading to lower premiums. In addition, people with insurance generally seek care sooner, rather than later, which could help save money. Conversely, individuals without insurance tend to use more expensive health care services such as emergency room visits, which can drive costs up.

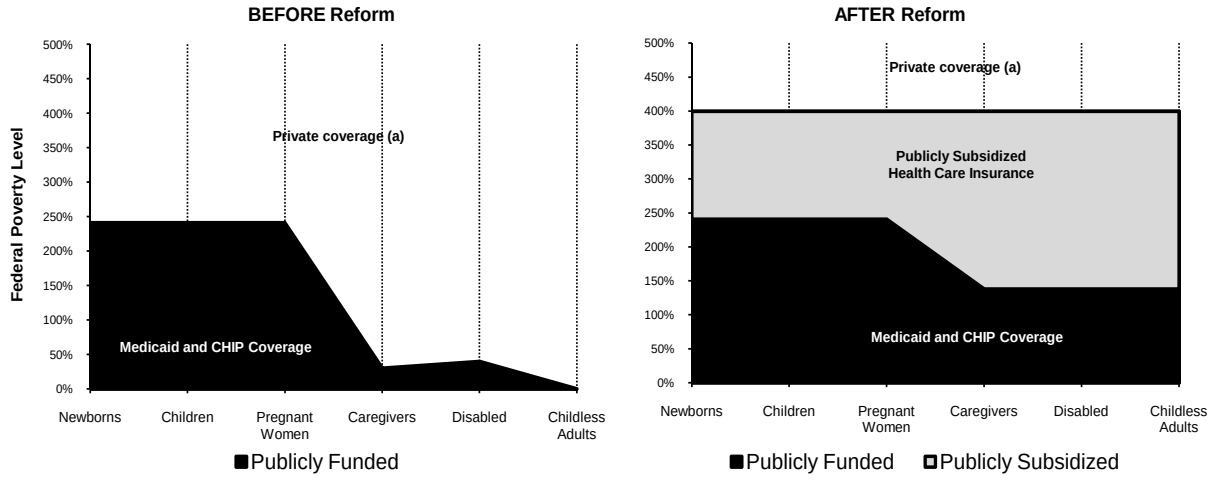
The mechanisms for increasing health care coverage (through increased public subsidies and individual mandates) are described in the previous section.

- **Increasing the emphasis on wellness and prevention, as well as increasing the number of health care providers**. Focusing efforts on overall health and wellness to prevent disease and injury can avoid or reduce expensive treatments or services that become necessary when diseases develop or progress without being diagnosed. An effective primary care system can produce cost savings by eliminating costly services (such as emergency room visits for non-emergency situations). Further, having more people cared for by a primary care provider could increase compliance with instructions on taking medications and help people make lifestyle changes.

- **Increasing efforts to identify and reduce waste, fraud, and abuse**. Examples of these initiatives include enhanced oversight for new providers and suppliers, compliance program requirements for Medicaid and Medicare providers and suppliers, increased penalties for false claims, and data sharing across federal and state programs.

- **Increasing regulation over health insurance premiums**. Federal health care reform will require insurance companies to spend at least 80% of the premium dollars they collect on health care. In turn, State insurance regulators will review how much the insurance companies spend on clinical services, quality, and other costs. Through these rate reviews, state regulators will determine whether insurance companies are in compliance.

Figure 2-1
Health Insurance Coverage Before and After Federal Health Care Reform



As shown in the graph on the left, before reform, Medicaid and the Children's Health Insurance Program covers children and some adults, depending on their income. After reform, as shown in the graph on the right, Medicaid and the Children's Health Insurance Program will cover substantially more people. Also, government subsidized private health insurance will become available to those with incomes up to 400% of the federal poverty level.

(a) Private health insurance coverage is typically employer-sponsored coverage. Individuals not getting insurance coverage will be subject to tax penalties beginning in 2014.
Source: LPA analysis of Medicaid eligibility thresholds and federal health care reform information

- **Increasing the use and sharing of electronic health information**. Passed as part of the American Recovery and Reinvestment Act (ARRA) in 2009, the Health Information Technology for Economic and Clinical Health (HITECH) Act included provisions to encourage health care providers to use and share clinical health data electronically. These efforts are expected to reduce health care costs by eliminating unneeded and redundant tests (such as certain blood work or x-rays) by streamlining administrative and patient records, and by accelerating and increasing the accuracy of care.

Health care reform also is intended to increase accessibility to essential health care services. Major components intended to do that include:

- **Creating temporary insurance plans for hard-to-insure individuals and eliminating restrictive insurance practices**. Health care reform created temporary high-risk insurance pools to provide coverage for individuals with pre-existing medical conditions. In Kansas, this pool is already in place and is managed by the Kansas Insurance Department. The program will remain in place until January 2014, the date when regular insurance programs will be prohibited from denying coverage to adults.

  Other provisions to improve access to health care include such things as prohibiting new insurance policies from having pre-existing condition exclusions for children, and prohibiting lifetime limits on the dollar value of coverage. In addition, health care reform prohibits insurance companies from rescinding coverage for any reason, except in cases of fraud. Finally, as of September 2010, health care reform also requires dependent coverage for adult children up to age 26.

- **Increasing the number of health care providers**. Health care reform includes several provisions aimed at increasing the health care provider workforce. Examples of such provisions include increasing graduate medical education training positions, providing scholarships, grants and loans, and developing special health training programs at federally qualified health centers or hospitals (for example, the dentistry training program was expanded to address the shortage of dental providers).

- **Increasing the care capacity of safety net clinics**. Under the reform, new funding was authorized to support current and new federally qualified health centers, and if appropriated, will increase from $3 billion in 2010 to $8 billion in 2015. Additionally, the health care reform authorized about $11 billion in competitive grant funds to expand, renovate, and construct new community health centers over the next five years. These clinics are referred to as “safety net” clinics because they provide care in underserved geographic areas and to underserved populations. Currently, Kansas has about 40 such clinics.

- **Creating an ombudsman program to assist with health insurance questions or complaints**. The States’ insurance regulators will be in charge of creating this program designed to assist customers with enrollment and complaints related to the new insurance requirements.

As mentioned before, this summary only focuses on the major components of the reform that likely will affect the State's responsibilities. It's important to note that health care reform includes numerous other changes that will affect individuals. We haven't attempted to summarize all those provisions in this report.

Appendix C lists a number of resources to consult for more information on federal health care reform.

Implementing Federal Health Care Reform Will Require Significant Coordination Among State Agencies

Because several State agencies in Kansas currently administer health-care related programs, implementing federal health care reform will require signif cant coordination. In addition, State agencies that previously had little involvement in health-care related programs likely will have signif cant roles—including the Kansas Insurance Department, the Department of Commerce, and the Department of Revenue. Below, we discuss each of these issues in more detail.

Unlike a number of other states, Kansas doesn't have one entity in charge of implementing health care reform. As shown below in ***Figure 2-2***, three main agencies are responsible for implementing the major components of health care reform in Kansas—the Kansas Health Policy Authority, the Kansas Insurance Department, and KDHE. In addition, SRS and the Department on Aging will be involved in specif c changes to the State's Medicaid Plan as it relates to reform.

Figure 2-2
State Agencies Involved in Implementing Major Components of Federal Health Care Reform

Component	KHPA	Kansas Insurance Department	KDHE
GOAL 1: Reduce the number of people without health insurance			
Expanding Medicaid coverage to include low-income, childless adults	✓		
Increasing funding for the Children's Health Insurance Program	✓		
Offering federal subsidies through health insurance exchanges		✓	
Offering tax credits and imposing tax penalties		(a)	
GOAL 2: Slow the increase in health care costs			
Investing in wellness and prevention			✓
Identifying and reducing waste, fraud, and abuse	✓	✓	
Creating and encouraging health care providers' use of Health Information Technology (HIT)	✓		✓
Health insurance rate reviews		✓	
GOAL 3: Increase accessibility of essential health care services			
Temporary insurance plans for hard-to-insure individuals		✓	
Increased funding for safety net clinics			✓
Ombudsman and consumer assistance program		✓	

(a) The federal government likely will lead implementing these provisions. At this point, it's unknown which State agency will have additional responsibilities related to this area.

Source: LPA review of published descriptions of federal health care reform and information provided by State agencies.

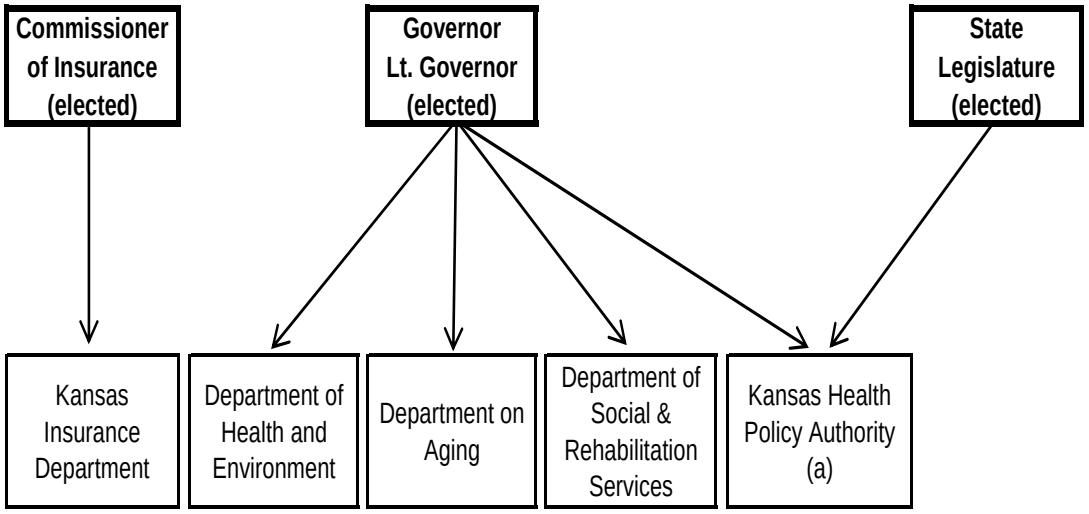
The organizational structure of Kansas' health-care related agencies will make coordination more diff cult to achieve. We've summarized the structure below in ***Figure 2-3***.

As the f gure shows, the Insurance Department reports to the Insurance Commissioner (who is a Statewide elected off cial). The Health Policy Authority, while part of the executive branch, reports to a separate Board made up of nine voting members appointed by the governor and legislative leadership, as well as eight non-voting ex-off cio members. The other agencies are part of the executive branch, and report to the Governor.

Currently, about 20 other states have created statewide initiatives to implement health care reform. These states' initiatives were set up in a variety of ways and include task forces, reform cabinets, and steering committees. They generally have similar tasks, such as implementing key reform provisions, and evaluating and recommending strategies to implement health care reform eff ciently and effectively.

For example, Colorado's "Interagency Health Reform Implementing Board" is responsible for coordinating that state's efforts to implement and monitor health care reform.

Figure 2-3
Organization of the Major Health-Care Related Agencies in Kansas



(a) The nine voting members of the KHPA board are appointed; 3 by the Governor and 6 by legislative leadership.
Source: FY 2011 Governor's Budget Report and KSA 75-7401

In contrast, Kansas doesn't have a Statewide coordinator. Each State agency appears to be focused primarily on aspects affecting only their portion of health care reform. Without one entity to oversee, coordinate, and facilitate health care reform issues, it's more likely that critical decisions will be delayed. Lastly, with multiple agencies involved, there's more potential for interagency disagreements and inaction.

State agencies will need to coordinate health care reform in a number of areas. The areas we identif ed are discussed in more detail below:

- **The Health Policy Authority and the Kansas Insurance Department will need to integrate Kansas' eligibility systems for Medicaid and private insurance exchanges**. The Kansas Insurance Department, through a federal grant, has taken the lead in developing an eligibility system for implementing the private insurance exchange system required by federal health care reform. Officials said this was appropriate because health care reform emphasizes general insurance, whereas Medicaid often is perceived as a welfare program.

  However, the Health Policy Authority has also received a grant to develop a new Medicaid and Children's Health Insurance (CHIP) eligibility system. Officials told us the system positions the State to process applications for the newly-eligible Medicaid population efficiently, and would be capable of incorporating insurance exchange eligibility (the same system the Kansas Insurance Department is currently planning for) when the time comes. Although health care reform mandates a simplified enrollment process for the Medicaid and the private insurance exchanges, the two agencies don't appear to be actively coordinating as well as they could.

  As of December 2010, there were signs that the agencies were beginning to coordinate their work. For example, the agencies had applied for a competitive federal grant. Funds from the "Early Innovator" grant are meant to help states design and implement the information technology infrastructure needed to operate private health insurance exchanges. According to officials from both agencies, the funding would benefit Kansas in several ways, including lowering the cost to create a behind-the scenes link between the Health Policy Authority's new eligibility system (described above) and the private insurance exchanges managed by the Kansas Insurance Department.

  Potentially complicating issues further is the fact that SRS' eligibility system is antiquated and needs to be replaced. This system currently is used to process applications for Medicaid, the Children's Health Insurance Program, and Temporary Assistance to Needy Families (TANF),disability, and food stamps. As currently planned, the Health Policy Authority's new eligibility system (mentioned above) will only include processing capability for Medicaid and the Children's Health Insurance Program. SRS and Health Policy Authority officials both told us they have discussed coordinating. However, the current Request for Proposal for the Authority's new eligibility system doesn't include SRS'

welfare programs. Nevertheless, agency officials stated that the addition of those eligibility components hasn't been ruled out yet.

- **The Health Policy Authority and the Kansas Insurance Department will need to coordinate an insurance ombudsman program**. Health care reform mandates an ombudsman program within each state's insurance regulation entity. Among other things, the program must handle complaints and appeals, and must provide the federal government with periodic reports. The Kansas Insurance Department will be in charge of the State's ombudsman program.

  Currently, the Kansas Health Policy Authority handles complaints related to Medicaid and the Children's Health Insurance Program and forwards Medicaid-related fraud complaints to a special Division of the Attorney General's Office. Because federal health care reform requires the ombudsman program to report complaints, the agencies will need to work together to ensure that consumers address complaints to the appropriate agency, and to share consumer complaint data for federal reporting purposes.

- **The Department of Commerce and other agencies need to work together to address the shortage of health care providers**. Currently, a couple of Kansas agencies have some involvement in addressing medical provider shortages. The Board of Regents administers several student assistance programs related to health care including nursing, osteopathic, and optometric scholarships. As part of health care reform, the Department of Commerce has worked with SRS, the Department of Labor, the Board of Regents, and other agencies to coordinate efforts related to two health care training grants (totaling $15.5 million) from the U.S. Department of Health and Human Services.

  In the future, formal collaboration will be key to identifying short- and long-term goals, as well as to ensure that Kansas takes advantage of other grant opportunities to decrease health care workforce shortages.

- **No one entity is responsible for coordinating the pursuit of available grant funding**. Kansas doesn't have a single State entity in charge of finding and coordinating grant funds related to health care reform. Instead, each agency reviews information on health care reform and any related grant opportunities individually. For example, officials from the Health Policy Authority, SRS, KDHE, and the Department on Aging told us they communicate with their respective federal counterparts to learn about grant opportunities. This approach might cause the State to miss grant opportunities because grants often have short application timeframes and individual agencies may not have the staff or expertise to pursue the grants.

- **Several agencies are involved in coordinating the federal Health Information Technology (HIT) initiative**. A number of entities are involved with implementing Health Information Technology provisions mentioned earlier in this report. This increases the risk that coordination efforts will fail or be inefficient. Here's a summary of the various entities involved:

- KDHE is the designated agency to develop and implement a Statewide plan related to the federal Health Information Technology initiative.

- The Health Policy Authority is responsible for the State's Medicaid health information technology plan, which includes providing Medicaid incentive payments to providers to encourage the use of electronic medical records and increased technology.

- The Governor has also created an entity called the "Kansas Health Information Exchange Inc." which is charged with initially building a business model for sharing electronic medical records. This system will be called the "Health Information Exchange," and will be run by this same entity.

- Finally, the Kansas Foundation for Medical Care will help coordinate federal funds meant to help medical providers' adopt electronic health record systems.

Again, because so many different entities are involved, it will be important for them to coordinate in order for the federal Health Information Technology initiative to be successfully implemented in Kansas.

Kansas Is Taking Steps To Implement Health Care Reform, But It's Too Early To Know Whether the State Is on Track

As mentioned before, the Health Policy Authority, KDHE, and the Kansas Insurance Department are responsible for major components of health care reform, while other agencies such as SRS and the Department on Aging are involved to a lesser extent. Below we describe Kansas' progress in implementing health care reform thus far.

State agencies have taken some steps toward implementing health care reform, such as procuring a number of federal grants and preparing to award contracts. Agency off cials told us they are receiving directions periodically from their federal counterparts and they are working to educate themselves about the provisions that likely will be their responsibility. ***Figure 2-4*** on the next page summarizes the specif c steps that State agencies have already taken or the work they have in process.

As the f gure shows, the Health Policy Authority, KDHE, and the Kansas Insurance Department have entered into contracts or received a number of grants to implement the f rst phases of health care reform initiatives and to learn about the f nancial effect of reform in Kansas.

However, it's diff cult to determine whether Kansas is on track in implementing health care reform for the reasons described on page 24.

Figure 2-4 Major Actions State Agencies Have Taken To Implement Certain Health Care Reform Provisions	
Agency	**Accomplishment**
KHPA	**Financial evaluation of the fiscal effect of federal health care reform on Kansas**. The Kansas Health Policy Authority contracted with Schramm-Raleigh, an independent actuarial firm, to do this. A summary of the results were released in May and are available on the agency's website (http://www.khpa.ks.gov/ppaca/KHPA_Analysis.html)
	Medicaid recovery audit contract. The Health Policy Authority is in the process of awarding a contract for additional audit services. This contract fulfills the health care reform requirement for Medicaid recovery audit services which are to be implemented by December 31, 2010.
	Plans for a new computer eligibility system for Medicaid. The Health Policy Authority received a five-year federal grant totaling $40 million for a new computer system and better outreach efforts for eligible Medicaid and Childrens Health Insurance Program individuals. The agency released a request for proposal for the computer system in October.
	State Medicaid Health Information Technology (HIT) Plan. The Health Policy Authority is responsible for making Medicaid incentive payments to providers whose electronic record systems have been certified. To understand the current status of providers' record systems, and to create a plan to evaluate and make those payments, KHPA received a $1.5 million grant to survey providers, and to procure a contract for its Medicaid HIT plan.
KDHE	**State Health Information Technology (HIT) Plan**. As the State's designated HIT entity, the Department of Health and Environment received a 4-year contract totaling $9 million. The first installment of $900,000 paid for the creation of a State HIT plan which is currently being evaluated by the federal government.
Kansas Insurance Department	**Insurance Exchange Planning**. The Kansas Insurance Department received a $1 million federal grant to plan for an insurance exchange system over the next year.
	Rate Review Planning. As part of the reform, insurance companies will be required to pay out at least 80% of its premiums in claims. The Department received a $1 million federal grant to plan for and pilot a review program.
	New Temporary High-Risk Pool. The Kansas Insurance Department received $36 million in federal funds to create a pre-existing condition insurance plan to make health care insurance available to people who otherwise couldn't find affordable coverage. The plan went public in July and as of early December 2010, 121 Kansans were enrolled.
	Ombudsman Program. The Kansas Insurance Department has received a $315,000 federal grant to provide consumer education and information about health care reform and how it affects individuals and families. As part of the grant, the agency plans to hold several community forums to answer questions and provide information. Customer assistance is one of the components the Ombudsman Program will include when fully operational by 2014.
Source: Interviews with agency officials and review of contract or grant documents.	

Many key provisions of the health care reform won't become effective until 2014, and some federal regulations affecting health care reform haven't been finalized. As mentioned before, we gained a general understanding of health care reform, and concentrated on the provisions affecting State agencies. In our review, we learned that agencies have taken steps towards implementing various provisions, but we also learned that a number of decisions will need to be made within the year and in the years to come. For example, Kansas will need to decide whether and how to:

- run the private insurance exchange market (as opposed to having the federal government doing it).
- enter into interstate compacts to allow interstate sale and purchase of health insurance.
- decide what changes to make to the State's Medicaid Plan—such as whether to change Kansas' home and community-based services waivers, or whether to offer services beyond the "essential benefits package" envisioned in health care reform.

According to agency off cials, many of the decisions they'll need to make depend on receiving more specif c guidance—such as regulations—from the federal government. While the federal Department of Health and Human Services (HHS) issues daily webcasts, updates, bulletins, training, and conference calls related to health care reform, other questions remain unanswered as of now. For example, HHS hasn't f nalized regulations that designate the "essential" insurance benef ts that will be mandatory for government-sponsored health insurance plans.

Because federal health care reform information will be continually updated, we've included a list of websites related to federal health care reform in ***Appendix C***.

State-level leadership recently has changed and agency officials are waiting to get direction from the new administrations. In November 2010, Kansas elected a new Governor as well as a new Attorney General. During the campaigns, both candidates openly opposed federal health care reform and favored repealing it. Agency off cials we talked with told us that their future efforts related to health care reform would depend on the directions given by new leadership.

Conclusion:	*Kansas has seven State agencies providing almost 60 health-care related programs, which increases the risk that services won't be well coordinated. We did find some instances where coordination could be better, but we didn't find any large pervasive problems. Of much more importance is impending federal health care reform, which will create altogether new coordination issues. That's because under federal health care reform, State agencies that currently manage health care programs—the Health Policy Authority, the Department on Aging, and the Department of Health and Environment—will have added responsibilities, and agencies that previously had little involvement—such as the Kansas Insurance Department—will now have a role. With none of these agencies fully in charge, it's critical that Kansas have one entity step up and provide clear direction.*

RECOMMENDATIONS FOR EXECUTIVE ACTION:

1. To ensure that the provisions of federal health care reform requiring State-level action are implemented as effectively and eff ciently as possible, the Governor should designate one entity to coordinate Kansas' health care reform efforts, including resolving health care reform implementation problems or interagency disagreements in a timely manner.

   That entity should:

   a. identify available federal grants related to the health care reform, and work with State agencies other Kansas entities to pursue these funding opportunities.

   b. track and report to the Legislature the status of health care reform implementation, including recommendations for legislation as needed.

2. To help ensure that health care programs are well coordinated, State agencies should do the following:

   a. The Health Policy Authority and KDHE staff should share data periodically to identify and notify consumers who are eligible for the federal Women, Infants and Children Program.

   b. The Department of Corrections and SRS should establish a process for sharing inmate/patient discharge information for inmate releases from Larned State Hospital, and revise their memorandum of agreement to ref ect that process.

c. The Health Policy Authority and SRS off cials should coordinate their contracts for mental health services delivered starting July 2012, with the goal of eliminating current redundancies and costs associated with two separate contracts for mental health services.

d. SRS and JJA should develop a memorandum of agreement to have SRS process Medicaid claims on behalf of the Juvenile Justice Authority.

3. To realize potential savings from billing certain inmate health care services to Medicaid, the Health Policy Authority and the Department of Corrections should work together to:

   a. process Medicaid eligibility applications for inmates who have or will be provided inpatient medical services.

   b. ensure that the Health Policy Authority's new eligibility system (which is expected to be up and running in 2014) will be able to easily process Medicaid eligibility for these inmates.

APPENDIX A

Scope Statement

This appendix contains the scope statement for this audit approved by the Legislative Post Audit Committee on April 27, 2010. The audit was requested by Representative Bob Bethell.

Health-Care Related Services: Reviewing Options for Consolidating or Better Coordinating the State's Health-Care Related Programs

A 2007 Legislative Post Audit identified seven State agencies that play some role in providing health-care related services to Kansans. They include the Department of Social and Rehabilitation Services, the Kansas Health Policy Authority, the Department on Aging, the Department of Health and Environment, the Commission on Veterans Affairs, the Department of Corrections, and the Juvenile Justice Authority.

Among the services those agencies provide are medical services; medical insurance for the financially disadvantaged; care and counseling for veterans, the elderly, developmentally disabled, and mentally ill; and preventive health services through local health departments.

Recently, legislators have raised questions about whether the delivery system for health-care related services in Kansas could be revamped to reduce costs, eliminate service gaps, and improve coordination, accountability, and efficiency.

A performance audit of this topic would answer the following question:

1. **Could costs be reduced or services offered more effectively by consolidating or better coordinating the health-care related services performed by State agencies?** To answer this question, we would review the health-care related functions performed by the Health Policy Authority, the Department of Health and Environment, SRS, the Department on Aging, and other State agencies. We would look across the types of services provided by the individual programs to determine whether certain programs are providing similar services to similar populations and whether the potential exists for reducing costs or improving service delivery by streamlining those services. We would interview officials and review documents as necessary to determine the extent to which the officials from these programs coordinate with each other to avoid duplication and reduce service gaps. We would conduct additional work in this area as needed.

Estimated Resources: 3 staff for 14-18 weeks (plus review)

APPENDIX B

State-Administered Health Care Programs

This appendix contains a listing and brief description of State-administered health care programs, by State agency. The information is based on self-reported program information agencies provided us. A similar program inventory, which included cost information, was compiled for our 2007 audit on health-care related programs.

Appendix B
State-Administered Health-Care and Long-Term Care Programs for Seven State Agencies (FY 2010)

Kansas Health Policy Authority Programs

Children's Health Insurance Program (CHIP): This program is a federal/state partnership but is funded as a block grant rather than as an entitlement like Medicaid. It's designed to provide health insurance coverage to children whose families earn too much to qualify for Medicaid but too little to afford private insurance.

Medicaid: Health insurance program for low income individuals, the aged, and people with disabilities. Medicaid is a federal-state program and as a condition of participation states must agree to cover certain populations and certain services.

MediKan: Time-limited, State funded health coverage program for adults with disabilities who do not qualify for Medicaid but are eligible for services under the State's General Assistance program.

State Employee Health Plan: The State of Kansas offers health coverage benefits to its employees and their dependents. SEHP has been expanded to include other employer groups including employees of Kansas public school districts, community colleges, technical colleges, vocational technical schools, and certain units of local government.

State Self Insurance Fund: KHPA administers the workers compensation program for state of Kansas employees. It is a self insured, self-administered program funded by agencies based on experience rating

Working Healthy/WORK: Federally funded grant program that encourages, supports, and sustains employment of people with disabilities through education, outreach and program promotion, facilitating health insurance enrollment and premium oversight, and providing supplemental personal assistance.

Kansas Department of Social and Rehabilitation Services (SRS) Programs

Developmental Disability Grants: Funding for adult day services, out-of-home residential services, and family support services for consumers with development disabilities.

Developmental Disabilities—Home and Community-Based Services (HCBS): Community-based services for consumers with developmental disabilities. Services are Medicaid reimbursable.

Developmental Disability–Hospitals: Long-term residential care, treatment and training for consumers with developmental disabilities at the Kansas Neurological Institute (KNI) and Parsons State Hospital and Training Center.

Intermediate Care Facility for Persons with Mental Retardation (ICFMR): Long-term residential care for consumers with mental retardation.

Mental Health—Medicaid-funded, Community Mental Health Services: Community based mental health services provided to Medicaid or MediKan eligible consumers. Includes the Home and Community Based Services Waiver for children with a serious emotional disturbance and the psychiatric residential treatment facilities community based alternatives grant.

Mental Health—Hospitals: Inpatient mental health treatment at Larned State Hospital, Osawatomie State Hospital, and Rainbow Mental Health Facility. Depending on definitions this could include civilly-committed sex predators, and competency evaluations and mental health treatment for those at the State Security Hospital.

Mental Health—Inpatient Psychiatric Services: Contracts for inpatient psychiatric services as an alternative for State mental health hospital services. This includes contracts with KVC STAR, KVC Wheatland, COMCARE/Via Christi, and Prairie View.

Mental Health—Community Mental Health Services Grants: Funding provided to Community Mental Health Centers to help provide services to consumers who have no other means of payment.

Mental Health—Community Support Drug Program: Funding source to provide mental health drugs to consumers who have no other means of payment.

Mental Health--Nursing Facility for Mental Health: Residential care and treatment for adults with a severe and persistent mental illness.

Mental Health--Psychiatric Residential Treatment Facility: Residential care and treatment for children with a serious emotional disturbance.

Other-Autism Waiver: Designed to provide intensive early intervention services to children with Autism Spectrum Disorders between the ages of 0 through 5. Services are designed to provide intensive early intervention by increasing the child's functional skills, replacing challenging behavior, and improving quality of life.

Other–Head Injury Rehabilitation Hospital: Inpatient rehabilitation for consumers with traumatic brain injuries.

Other–Technology Assistance Waiver: This program is used to assist children who are medically fragile between the ages of 0-22 by providing in-home supports and case management. These children are dependent on technology to sustain life.

Physical Disability, Home and Community-Based Services (HCBS): Community-based services for consumers with physical disabilities. Services are Medicaid reimbursable.

Positive Behavior Support Services: Specialized behavior management strategies provided to children 21 years and younger. Children receiving these services have severe behavioral challenges.

Appendix B
State-Administered Health-Care and Long-Term Care Programs for Seven State Agencies (FY 2010)

Kansas Department of Social and Rehabilitation Services (SRS) Programs (cont)

Substance Use Disorder—Medicaid-funded Treatment for Medicaid eligible consumers: Community based substance use treatment services provided to Medicaid eligible consumers.

Substance Use Disorder—Treatment Grants: These grants pay for treatment provided to low income consumers who aren't eligible for Medicaid.

Substance Use Disorder—Treatment: Treatment for 4th Time DUI Offenders who are placed in the custody of KDOC

Targeted Case Management for the Developmentally Disabled: A service to coordinate the care of consumers with developmental disabilities.

Traumatic Brain Injury, Home and Community-Based Services (HCBS): Community-based care and rehabilitation services for consumers with Traumatic brain injuries. Services are Medicaid reimbursable.

Kansas Department on Aging Programs

Chronic Disease Self Management Program (CDSMP): Establishes an infrastructure to implement the Stanford CDSMP within the aging and public health networks. It recruits and trains volunteer trainers who conduct a six week workshop to help older Kansans learn skills to manage their chronic disease(s).

Disease Prevention and Health Promotion-Older Americans Act, Title III-D: Various prevention services provided to seniors age 60 and older. Includes such services as health risk evaluations, nutrition counseling, health promotion programs, medication management, and physical fitness.

Frail Elderly, Home and Community-Based Services (HCBS): Services to people aged 65 and older who need help with multiple activities that adults normally can perform for themselves, such as bathing and shopping.

In-Home Services-Older Americans Act, Title III-B: Services to help seniors age 60 and older to remain in their homes and communities. Services include, for example, attendant care, respite, home health, and adult day care.

Nursing Facilities: Long-term care services provided in an institutional setting.

Program of All-Inclusive Care for the Elderly (PACE): Provides social and medical services primarily in an adult day health center, which is supplemented by in-home and referral services as consumers need them. Consumers must be at least 55 years old and eligible for nursing home care. The program is funded with integrated funds from Medicaid and Medicare.

Seniors Enjoy Physical Success (STEPS): Fitness classes for seniors age 60 and older to improve physical and mental health, increase social functioning and to reduce health care costs by minimizing chronic conditions.

Senior Care Act: Funding to help develop a coordinated system of in-home services for seniors age 60 and older who face difficulties with self-care and independent living. The system helps prevent inappropriate or premature institutionalization.

Kansas Department of Health and Environment Programs

Breast and Cervical Cancer Program: Education and screening services to reduce deaths caused by breast and cervical cancer by providing services to women who meet age and income eligibility guidelines. These funds also support a Statewide cancer registry program and comprehensive cancer implementation plan.

Childhood Lead Poisoning Prevention: Provides for medical surveillance and case management of children with elevated blood lead levels.

Disease Prevention and Health Promotion Federal Grants: Provides services to prevent Tuberculosis, primary and secondary disabilities, and the like. Rural areas also receive funding to provide for hospitals and clinics.

HIV/AIDS Education and Risk Reduction: Expenditures reported here are only that portion of the grant used to provide for the care of people living with HIV infection and AIDS.

Immunization Program: Provides vaccines and age-appropriate immunizations for children in Kansas to prevent the spread of vaccine-preventable diseases.

Infants and Toddlers with Disabilities, Individuals with Disabilities Education Act (IDEA),Part C: Early intervention services for infants and toddlers with disabilities.

Maternal and Child Health Services Block Grant Program, Title V: Funding helps assure access to quality maternal and child health services to reduce infant deaths and preventable disease. It's also used to help provide a system of community based services for children with special health care needs.

Medicare Funding for Health Care Facility Certification Process: These funds reimburse Kansas for actual expenses incurred for licensing or certifying hospitals, ambulatory surgical centers, home health agencies, and other medical care providers.

Migrant Health Program: Case managers arrange access to primary health care for migrant and seasonal farm workers.

Oral Health Program: Provides oral health training and fluoride varnishing for children.

Appendix B State-Administered Health-Care and Long-Term Care Programs for Seven State Agencies (FY 2010)
Kansas Department of Health and Environment Programs (cont)
Primary Care Grant Program: The agency provides operating and capital improvement grants to safety net clinics throughout the State. **Ryan White Title II Grant:** Funds are used to support a wide range of services for people with HIV, including direct health and support services, home and community-based healthcare and supportive services, continuum health insurance coverage as well as pharmaceutical treatments. **Sexually Transmitted Diseases:** Intervention, prevention, and surveillance activities to prevent the spread and complications of Gonorrhea, Chlamydia, Syphilis and HIV.
Kansas Department of Corrections Programs
Chemical Dependency Recovery Program: Substance abuse treatment services provided to minimum custody inmates at Larned Correctional Mental Health Facility. **Medical Services for Inmates:** Medical, mental health, dental, optometry and pharmaceutical services for inmates in Kansas' correctional facilities, with some funding from federal reimbursements for costs associated with undocumented immigrants.
Juvenile Justice Authority Programs
Health Care Oversight and Management: Provide advice and recommendations to JJA Executive Team and Facility Superintendents regarding youth medical issues, policies, and procedures, oversight of medical and psychiatric contracts, and quality assurance. **Medical and Mental Health Services** for youth committed to the Kansas Juvenile Correctional Complex and Larned Juvenile Correctional Facility, including contract physicians and psychiatrists, local hospitals, specialists, nursing staff, and pharmaceuticals. **Psychiatric Residential Treatment Facilities:** comprehensive mental health treatment to youth who, due to mental illness, substance abuse, or severe emotional disturbance are in need of treatment that can most effectively be provided in a residential treatment setting.
Kansas Commission on Veterans Affairs Programs
Kansas Soldier's Home: Offers three levels of care for veterans and their dependents, including independent living cottages, assisted living units, and a nursing care center. The Home is located near Dodge City. **Kansas Veteran's Home:** Provides three levels of care to Kansas veterans and their dependents, including long-term nursing care, assisted living, and special care for Alzheimer's patients. The home is located at the former Winfield State Hospital.
Source: LPA summary of agency-reported program information

APPENDIX C

Resources for More Information on Federal Health Care Reform

Because federal health care reform information will be continually updated, even after this report is issued, we've included a list of websites related to federal health care reform in this appendix. These links provide a wealth of additional information about health care reform, including Kansas-specific federal reform information, interactive reform timelines, and federal government websites.

Kansas-specific information related to federal health care reform:

- *Kansas Health Policy Authority*: http://www.khpa.ks.gov/ppaca/default.htm
- *Kansas Insurance Department*: http://www.ksinsurance.org/consumers/healthreform/hcr.htm
- *Kansas Department of Health and Environment* (Health Information Technology site)*:* http://kanhit.org/
- *Kansas Health Institute*: http://www.khi.org/news/health-reform/
- *United Methodist Health Ministry Fund*: http://www.healthfund.org/reportspubs/hcreform.php
- *U.S. Department of Health & Human Services*: http://www.healthcare.gov/center/states/ks.html

Timelines related to implementing federal health care reform:

- *Kaiser Family Foundation:* http://healthreform.kff.org/timeline.aspx
- *National Conference of State Legislatures:* http://www.ncsl.org/documents/health/factsheet_keyprov.pdf
- *U.S. Department of Health & Human Services:* http://www.healthcare.gov/law/timeline/index.html
- *The White House:* http://www.whitehouse.gov/healthreform/timeline

Federal government information related to health care reform:

- *Congressional Budget Office* (Includes health reform cost estimates) *:* http://www.cbo.gov/publications/collections/health.cfm
- *Internal Revenue Service* (Affordable Care Act Tax Provisions)*:* http://www.irs.gov/newsroom/article/0,,id=220809,00.html
- *U.S. Department of Health & Human Services:* http://www.healthcare.gov/index.html http://www.cms.gov/Center/healthreform.asp http://www.hhs.gov/
- *The White House:* http://www.whitehouse.gov/healthreform

APPENDIX D

Agency Responses

On December 23, 2010, we provided copies of the draft audit report to the Department on Aging, to the Department of Social and Rehabilitation Services, Department of Corrections, and Health and Environment, as well as the Kansas Health Policy Authority, Kansas Insurance Department, Juvenile Justice Authority, Commission of Veterans Affairs, and the Governor's Office. The agencies' responses are included in this appendix. The agencies generally concurred with the report's findings, conclusions and recommendations.

Capitol Building
Room 241-South
Topeka, KS 66612

Kansas
Office of the Governor

phone: 785-296-3232
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governor@ks.gov
Sam Brownback, Governor

January 21, 2011

Scott Frank
Legislative Post Auditor
Legislative Division of Post Audit
800 SW Jackson St, Suite 1200
Topeka, KS 66612-2212

Dear Mr. Frank,

First, I would like to thank everyone at the Legislative Division of Post Audit for closely examining these important issues. The recommendations highlight the need for greater communication and coordination among state agencies and the identification of a single entity to be responsible for managing the future of our health care programs.

I have asked my Lt. Governor, Dr. Jeff Colyer, to convene a sub-cabinet of agency officials to begin working to reform the state's Medicaid program to improve services and lower costs. He will also work with a cross-section of health care leaders from outside of state government to explore innovative solutions to our citizens' health care needs.

I look forward to working with the legislature as we move forward.

Sincerely,

Sam Brownback
Governor of the State of Kansas

December 28, 2010

Scott Frank, Legislative Post Auditor
Legislative Division of Post Audit
800 Southwest Jackson Street, Suite 1200
Topeka, KS 66612-2212

Dear Mr. Frank:

This is in response to the competed performance audit, *Health-Care Related Services: Reviewing Options for Better Coordinating the State's Health-Care Related Programs.* The audit addressed the following two questions:

1) Could costs be reduced or services offered more effectively by better coordinating the health-care related services provided by State agencies?

2) How will federal health care reform affect Kansas' health-care related programs?

The audit report was informative and provided findings and recommendations for each of the questions. The Kansas Department on Aging (KDOA) looks forward to continuing its role in delivering Medicaid-funded long term care services and supports. The KDOA will also continue to monitor the federal health care reform and the programs which have a direct impact on the lives of our Kansas seniors.

Thank you for the opportunity to review the draft report. If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

Martin Kennedy
Secretary

Copies: Bill McDaniel
Bob Parker

PROGRAM AND POLICY COMMISSION
New England Building, 503 S. Kansas Avenue, Topeka, KS 66603-3404
Voice: (785) 296-4986 • Toll-Free: (800) 432-3535 • Fax: (785) 296-0256
TTY (Hearing Impaired): (785) 291-3167 • E-Mail: wwwmail@aging.ks.gov

January 4, 2011

Scott Frank
Legislative Post Auditor
Legislative Division of Post Audit
800 SW Jackson Street, Suite 1200
Topeka, Kansas 66612-2212

Re: Health-Care Related Services: Reviewing Options for Better Coordinating the State's Health-Care Related Programs

Dear Mr. Frank:

I am in receipt of and have reviewed the draft performance audit report regarding options for better coordinating the state's health-care related programs. Thank you for this opportunity to respond to the content of the report.

The first finding that affects the department directly is that the state could realize significant savings by billing Medicaid for some inpatient care provided to inmates in the corrections system. The savings would dramatically increase in 2014 under the terms of the 2010 Patient Protection and Affordable Care Act, which would expand Medicaid eligibility. Additional savings could be realized if the KDOC were able to pay at Medicaid rates for all inmate inpatient care similarly to what the county jails are able to do pursuant to 2006 HB 2893. The department agrees with the first finding and has the following two considerations:

1. The process for determining eligibility should be streamlined so that the process is not too staff intensive or lengthy which could delay treatment for inmates or payment for providers. The KDOC provides health care for inmates through a contract with a health care provider that provides a managed care approach. Generally, the duration for in-patient services is relatively short and the inmates could be admitted and released before eligibility is determined. The Department is willing to coordinate with KHPA to streamline the process by pre-determining eligibility or some other process that simplifies the eligibility determination.
2. As cautioned in the audit, health care providers are not compelled to serve inmate patients. If forced to bill at Medicaid rates, some providers near correctional facilities may potentially not accept inmate patients. This could result in increased costs for security and transportation to access treatment from providers who accept Medicaid payment rates.

The second finding is that the Department of Corrections and the Department of Social and Rehabilitative Services could better coordinate inmate releases from the Isaac Ray Unit at Larned State Hospital. Again, the KDOC agrees with the finding. Often the perspective of the two agency's staffs do not always agree, and the standards and policies of the two agencies seem to conflict. However, the KDOC is agreeable to continuing to work with SRS to determine a more effective release process and amend the MOA accordingly.

Sincerely,

Keven Pellant
Acting Secretary of Corrections

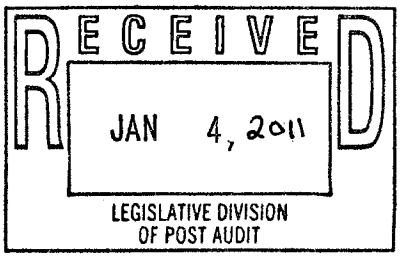
DEPARTMENT OF CORRECTIONS
900 S.W. Jackson Street, 4th Floor • Topeka, Kansas 66612-1284 • Tel: (785) 296-3317 • Fax: (785) 296-0014

KANSAS
DEPARTMENT OF HEALTH
AND ENVIRONMENT

Mark Parkinson, Governor
John W. Mitchell, Acting Secretary

www.kdheks.gov

January 3, 2010



Scott Frank
Legislative Post Auditor
Legislative Division of Post Audit
800 Southwest Jackson Street, Suite 1200
Topeka, Kansas 66612-2212

Dear Mr. Frank:

Thank you for the opportunity to provide comments on the draft performance audit, *Health-Care Related Services: Reviewing Options for Better Coordinating the State's Health-Care Related Programs.*

With respect to the draft audit report, we are in agreement with the findings and recommendations as they pertain to this agency. Previously, we communicated some minor wording clarifications and it is our understanding that modifications will be made in the report to accommodate our suggestions.

Finally, at the present time, WIC is able to share data with the Kansas Health Policy Authority because WIC participants, at every certification visit, sign a rights and responsibilities form which includes consent for outreach. Using the WIC database to send a letter to potentially eligible participants fits nicely within the scope of outreach.

In order for KHPA to obtain this information, a written request needs to be made to KDHE requesting ad hoc reports at specified intervals. Please let us know how we can help to expedite such a request.

Again, thank you for the opportunity to provide comments on this audit.

Sincerely,

John W. Mitchell
Acting Secretary,
Kansas Department of Health and Environment

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Voice 785-296-0461 Fax 785-368-6368

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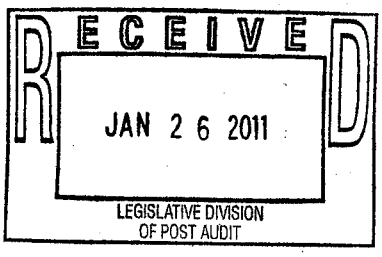
KANSAS HEALTH POLICY AUTHORITY

January 4, 2011



Mr. Scott Frank
Legislative Division of Post Audit
800 SW Jackson, Suite 1200
Topeka, KS 66612-2212

Dear Mr. Frank:

Thank you for the opportunity to review the draft audit report "Health Care Related Services: Reviewing Options for Better Coordinating the State's Health Care Related Programs". There are three recommendations that refer to the Kansas Health Policy Authority. Responses to each recommendation are provided below.

Recommendation 2a. The Health Policy Authority and KDHE staff should share data periodically to identify and notify consumers who are eligible for the federal Women, Infants, and Children Program.

The state Medicaid program currently does not obtain permission from applicants and beneficiaries to share personal income and eligibility data with assistance programs like WIC. Construction of a new Medicaid eligibility system may present opportunities to more directly coordinate applications for Medicaid and other assistance programs such as WIC. In the meantime, KHPA will work with officials at KDHE to identify Medicaid-eligible beneficiaries that could also be enrolled in WIC, and will develop and present to the KHPA Board a plan to notify these individuals of their eligibility for WIC benefits.

Recommendation 2c. The Health Policy Authority and SRS officials should coordinate their contracts for mental health services delivered starting July 2012, with the goal of eliminating current redundancies and costs associated with two separate contracts for mental health services.

As the report points out, the current contract for mental health services for the Children's Health Insurance Program (CHIP) meets the statutory requirement for a capitated managed care plan. KHPA has procured this service through a risked based contract in the same way that physical health services for CHIP are purchased. This is a different approach than is currently used in the SRS contract. KHPA will work with SRS to develop options for greater coordination of mental health services, including integration of the two contracts as each approaches its ending date in June 2012.

Rm. 900-N, Landon Building, 900 SW Jackson Street, Topeka, KS 66612-1220
www.khpa.ks.gov

Medicaid and HealthWave:
Phone: 785-296-3981
Fax: 785-296-4813

State Employee Health Benefits and Plan Purchasing:
Phone: 785-368-6361
Fax: 785-368-7180

State Self Insurance Fund:
Phone: 785-296-2364
Fax: 785-296-6995

Recommendation 3. To realize potential savings from billing certain inmate health care services to Medicaid, the Health Policy Authority and the Department of Corrections should work together to:

a) **process Medicaid eligibility applications for inmates who have or will be provided inpatient medical services**
b) **ensure that the Health Policy Authority's new eligibility system (which is expected to be up and running in 2014) will be able to easily process Medicaid eligibility for these inmates.**

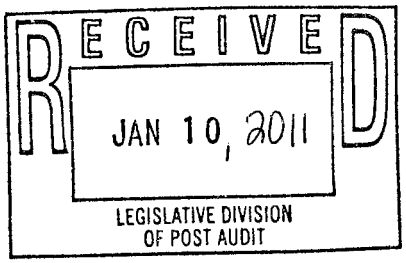
KHPA can ensure that the eligibility system that is under development will have greater flexibility to address the eligibility issues raised in this recommendation. The specifications for the system are still under development but the design will support greater customization by eligibility group and greater access by remotely located workers to update eligibility status. KHPA will investigate the success of other states in securing Medicaid funding for inpatient services provided to inmates. If the use of Medicaid funds is allowable, KHPA will work with the Department of Corrections to identify eligible inmates and eligible services. If savings and access to services can be assured, KHPA will work with the KDOC to implement this recommendation as soon as systems and policies can be put in place.

Sincerely,

Dr. Andrew Allison, Ph.D.
Executive Director
Kansas Health Policy Authority

Kansas Insurance Department

Sandy Praeger
Commissioner of Insurance



January 6, 2011

Scott Frank
Legislative Post Auditor
800 SW Jackson, Suite 1200
Topeka, Kansas 66612

Dear Mr. Frank:

Thank you for sharing the recently completed performance audit referred to as Health-Care Related Services: Reviewing Options for Better Coordinating the State's Health-Care Related Programs. We found the report both informative and affirming of current practices at our department.

We are supportive of the report's conclusions and appreciate the opportunity to work with your staff in providing information for this audit. Please let us know if you have further questions for us.

Sincerely,

Sandy Praeger

Sandy Praeger
Commissioner of Insurance

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KANSAS
JUVENILE JUSTICE AUTHORITY

Mark Parkinson, Governor
Dennis A. Casarona, Acting Commissioner
jja.ks.gov

December 30, 2010

Scott Frank
Legislative Post Auditor
Legislative Division of Post Audit
800 SW Jackson St, Suite 1200
Topeka, KS 66612

Dear Mr. Frank:

This letter is in response to your December 22, 2010 request to review a draft copy of the performance audit, *Health-Care Related Services: Reviewing Options for Better Coordinating the State's Health Care-Related Programs.* The draft report recommends that the Juvenile Justice Authority (JJA) and the Department of Social and Rehabilitative Services (SRS) develop a memorandum of agreement to have SRS process Medicaid claims on the behalf of JJA.

JJA will open discussions with SRS once the new administration is in place. Since such a MOU would require a shift in funding from JJA to SRS, JJA will also involve the Division of the Budget in these discussions.

Thank you for the opportunity to comment on the draft report. Should you or your staff have any questions or concerns please do not hesitate to contact Keith Bradshaw at 296-4252.

Sincerely,

Dennis A. Casarona
Acting Commissioner

714 SW Jackson, Ste. 300, Topeka, KS 66603 • (785) 296-4213 • Fax: (785) 296-1412
e-mail: jja@jja.ks.gov

KANSAS
DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

Mark Parkinson, Governor
Laura Howard, Acting Secretary

www.srs.ks.gov

January 3, 2011

Scott Frank
Legislative Post Auditor
800 SW Jackson Street, Suite 1200
Topeka, Kansas 66612

Thank you for the opportunity to review and comment on the draft copy of your performance audit, *Health-Care Related Services: Reviewing Options for Better Coordinating the State's Health-Care Related Programs*.

We agree with your recommendation that the Kansas Health Policy Authority (KHPA) and SRS should coordinate their managed care contracts for behavioral health services with a goal of eliminating the redundancies associated with two separate contracts. SRS currently manages the substance use disorder and community mental health managed care contracts. This allows SRS to fully coordinate all state, federal, and Medicaid funded behavioral health services statewide as expected by K.S.A. 75-7408 (b), 75-3304a, and 65-4001. KHPA manages one other behavioral health managed care contract funded by the State Children's Health Insurance Program (SCHIP). Kansans needing behavioral health services have benefited greatly from a coordinated state, federal, and Medicaid funded behavioral health system specifically designed and equipped for that purpose as envisioned by the statutes. More closely coordinating with the SCHIP behavioral health program would further improve the effectiveness and efficiency of the publicly funded behavioral health system. SRS acknowledges that there exist challenges to such an effort, including the statutory mandate on SCHIP for a risk-based contract, but we believe the challenges can be overcome and the benefits of a fully integrated public behavioral health system would be more than worth the effort.

SRS would certainly be willing to work with the Juvenile Justice Authority (JJA) to determine if SRS could monitor JJA's Medicaid claims payments, ensure appropriate accounting of the claims, and file federal Medicaid expenditure reports. SRS will initiate discussions with JJA regarding how we might be of assistance, and develop a memorandum of agreement as necessary.

SRS agrees that Larned State Hospital (LSH) and the Department of Corrections (DoC) must ensure that DoC, receive all of the post-discharge appointment information needed to help inmates' successful reintegration into the community. The Larned State Hospital Superintendent and the Larned Mental Health Correctional Facility Warden have both checked into concerns about this process. Both parties believe communication regarding discharges is important for a smooth transition and follow-up after release. Confidentiality requirements must be considered but do not restrict what LSH can appropriately share with DoC. SRS and DOC will work together to ensure the Memorandum of Agreement reflects what is necessary to continue this collaboration.

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We would also like to comment on the recommendation that KHPA and DoC work together to process Medicaid eligibility applications for inmates who have or will be provided inpatient services. Because SRS field staff play a large role in Medicaid eligibility determination for certain populations, SRS would also like to be involved in planning for this change, and will reach out to DoC and KHPA to ensure involvement in planning for this change.

On the topic of health reform, SRS concurs with the recommendation that the Governor designate an entity to coordinate Kansas' health reform efforts.

Finally, SRS would like to share other coordination efforts that, while not fully addressing the reports third concern in the section on "Broader Service Gap Issues", will greatly improve the effectiveness and efficiency of health care provided to Kansans with a mental illness and other physical health needs. SRS is working with KHPA and the Association of Community Mental Health Centers of Kansas to develop effective care coordination of physical and mental health treatment. Research shows that persons with a severe and persistent mental illness (SPMI) die 25 years younger than the general population due to preventable medical conditions. Other research shows that the Medicaid cost of serving these people is very high. Recently Missouri has shown that effective care coordination provided by community mental health centers can not only improve the health and wellness of persons with an SPMI, but result in substantial Medicaid cost savings. SRS is working diligently with KHPA and community mental health centers to develop effective care coordination to achieve the same outcomes in Kansas.

We appreciate the work your office has done in evaluating the efficiencies that can be gained in improved coordination of health care managed by state agencies. We look forward to working further on the recommendations made in your report.

Sincerely,

Laura Howard

Laura Howard
Acting Secretary

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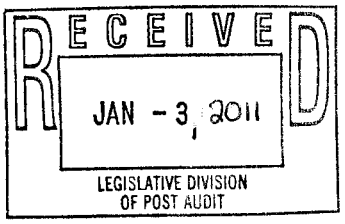
KANSAS COMMISSION ON VETERANS' AFFAIRS

Governor Mark Parkinson | Jayhawk Towers, 700 SW Jackson, Suite 701, Topeka, KS 66603-3758 (785) 296 3976 www.kcva.org (785) 296-1462 (Fax) | Executive Director Jack Fowler

January 3, 2010



Legislative Division of Post Audit
800 SW Jackson St, Ste. 1200
Topeka, KS 66612-2212

Re: Health-Care Related Services

The Kansas Commission on Veterans' Affairs (KCVA) thanks you for the report and appreciates the opportunity to respond to the Legislative Post Audit's report on *Health-Care Related Services: Reviewing Options for Better Coordinating the State's Health-Care Related Programs.*

The KCVA accepts the report and has no response or recommendations.

On behalf of the KCVA, I would like to thank you for your efforts during this audit. Your staff was courteous, knowledgeable, and receptive during all discussions and meetings.

Sincerely,

Jack Fowler
Executive Director
Kansas Commission on Veterans' Affairs