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2018 LEGISLATIVE PREVIEW

JANUARY 2018

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Anticipating key health policy themes

Introduction

During the 2017 Kansas legislative session, more than 80 health-related bills were introduced covering a wide range of subjects, including Medicaid expansion, controlled substances, behavioral health, scope of practice and vaccinations. Because 2017 was the first year in a legislative biennium, or two-year cycle, all bills that were still under consideration when the Legislature adjourned in June may be considered again in 2018.

Medicaid is one issue that could receive considerable attention during the 2018 session. Expansion advocates—encouraged by last year's outcome when a bill to expand Medicaid passed both the House and Senate, but was later vetoed by the governor—likely will ask legislators to again consider the issue. While the Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS) await a response from the Centers for Medicare and Medicaid Services (CMS) to the state's Section 1115 demonstration renewal application for KanCare 2.0 submitted at the end of 2017, legislators likely will consider the implications of the proposed changes to the program.

Legislators also may have an opportunity to consider a proposal to demolish and rebuild Osawatomie State Hospital (OSH) and enter into a contract with a private company to operate it. Other health-related issues that may be on the table include medical marijuana, policies to address the use and misuse of opioids, and the availability of resources to address the behavioral health needs of Kansans.

While legislators are considering health-related bills and policies, they also will need to address K-12 school funding again, after the Kansas Supreme Court held on October 2, 2017, that the funding bill signed by Gov. Sam Brownback on June 15 was unconstitutional. The Court has asked the Legislature to produce a new school finance formula by April 30, 2018, and has scheduled a hearing for May 22 to consider the Legislature's proposed plan.

If Gov. Brownback resigns to take a federal post as expected, the 2018 legislative session will take place while Lt. Gov. Jeff Colyer is transitioning to the governor's office.

Key health policy themes

Since 2017 was the first year in a legislative biennium, all bills that were still under consideration when the Legislature adjourned in June may be considered again in 2018.

Medicaid

Health policy advocates, encouraged by both the House and the Senate's passage of a Medicaid expansion bill last year, will likely ask legislators to again consider expansion. Legislators may also want to consider the implications of the proposed changes to KanCare 2.0.

Osawatomie State Hospital

Legislators may also have an opportunity to consider a proposal to demolish and rebuild Osawatomie State Hospital and enter into a contract with a private company to operate it.

Controlled substances

Medical marijuana and policies to address the use and misuse of opioids may also be on the table.

Telemedicine/Telehealth

Legislators will consider legislation to mandate insurance coverage for telehealth services.

KanCare

On October 27, 2017, KDHE and KDADS released a draft of their Section 1115 demonstration renewal application for KanCare 2.0, which would extend the program for another five years beginning January 1, 2019.

The draft application included several proposed changes to the existing KanCare program, including the addition of a 20–30 hours per week work requirement for some able-bodied adult enrollees. Those who meet the work requirements would be eligible for 36 months of coverage. To date, CMS has not approved the inclusion of work requirements in Medicaid programs, but state officials around the country believe that the Trump administration may be open to allowing states to implement this new requirement. Individuals in state hospitals or long-term care, pregnant women, children, individuals with children under age 6 or those caring for a household member with a disability, and individuals on any of the state's home and community-based services waivers would not be subject to the work requirement.

Other proposed changes for KanCare 2.0 include an expansion of care coordination to include services and supports focused on social determinants of health and independence, the development of service plans based on specific enrollee needs, and new expenditure authority for services provided to enrollees who are receiving services in an inpatient psychiatric institution, such as a state hospital.

Release of the draft started a 30-day public comment period that ended on November 26, 2017. During that time, state officials held 14 public hearings around the state to allow Kansans to ask questions and comment on the new plan. The final KanCare 2.0 proposal, including the public comments received, had to be submitted to CMS for approval in order to secure federal funding for the program.

On November 2, 2017, KDHE and KDADS posted a request for proposals from bidders interested in providing managed care services for KanCare 2.0. The agencies have stated that following evaluation of the responses—which are due by January 5, 2018—they will negotiate contracts with three or four managed care organizations (MCOs).

The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight met on November 28–29, 2017, and heard from individuals representing KanCare beneficiaries, providers and MCOs. They also viewed presentations from KDHE officials and Kansas Legislative Research Department (KLRD) staff about the draft KanCare 2.0 renewal application. Legislators then discussed and voted to approve several recommendations to be made to the full Legislature, including:

- Encouraging the administration to move forward with the KanCare 2.0 demonstration renewal application;
- Suggesting the administration consider the addition of more comprehensive dental benefits

KanCare enrollees exempt from proposed work requirements

Those receiving long-term care, including institutional care and Money Follows the Person
Kansans enrolled in the following Home and Community-Based Services (HCBS) waiver programs: Autism, Serious Emotional Disturbance (SED), Technology Assisted (TA), Frail Elderly (FE), Traumatic Brain Injury (TBI), Intellectual and Developmental Disabilities (I/DD), and Physical Disability (PD)
Children
Women who are pregnant
Enrollees who have disabilities and are receiving Supplemental Security Income (SSI)
Caretakers for dependent children under age 6 or those caring for a household member who has a disability
Medicaid beneficiaries who have an eligibility period that is only retroactive
Kansans enrolled in the MediKan program
Enrollees who are presumptively eligible for Medicaid
Kansans whose only coverage is under a Medicare Savings Program
Persons enrolled in Programs of All-inclusive Care for the Elderly (PACE)
Members with TBI, human immunodeficiency virus (HIV), or in the Breast and Cervical Cancer Program
Members who are over the age of 65 years
Certain caretakers of KanCare members 65 years and older who meet criteria specified by the state

for adult Medicaid enrollees in KanCare 2.0;

- Supporting reduction of the waiting list for home and community-based services (HCBS) and acknowledging KDADS' request for additional funding for its supplemental budget to address the waiting list;
- Considering a statewide study of the rate of suicide in Kansas—particularly among young adults—and legislation to address suicide prevention and prevention training;
- Providing KDHE with timeframes and definitions of what legislators want included in reports about eligibility issues and clearinghouse performance; and
- Reviewing and reforming the state's nursing home inspection system, including review of staff salaries and training, and fines for violations.

KanCare 1.0

To give states flexibility to design and improve their Medicaid programs, Section 1115 of the Social Security Act gives the secretary of Health and Human Services the authority to approve experimental, pilot or demonstration projects. The KanCare demonstration project, which privatized the Kansas Medicaid program, began operating on January 1, 2013, and was set to expire on December 31, 2017. Kansas requested a one-year extension for the program, which was denied in early 2017 by CMS, who ruled the program failed to meet federal standards and risked the health and safety of enrollees. The state submitted a corrective action plan, which was approved by CMS in May 2017. On October 13, CMS granted a one-year extension of the KanCare program—through December 31, 2018—provided that Kansas comply with various requirements included in the corrective action plan.

Medicaid Expansion

During the 2017 session, three bills to expand Medicaid in Kansas were introduced, two of them by the Kansas Hospital Association very early in the session. One of the bills, House Bill (HB) 2064, received a hearing but not a vote in the House Health and Human Services Committee. Later, it was amended into HB 2044 (related to mental health services), and was passed by both the House and Senate and forwarded to Gov. Brownback on March 27, 2017. When the governor vetoed the bill on March 30, the House failed to override the veto and the bill died. In his veto message, Gov. Brownback stated his objections to expansion, including concerns about the potential cost of expansion to the state and uncertainty about the outcome of ongoing congressional efforts to repeal, replace or modify the Affordable Care Act.

A poll released on May 8 by the American Cancer Society's Cancer Action Network and the American Heart Association found that 68 percent of Kansans surveyed support expansion. KHI has estimated that approximately 152,000 Kansans—including 98,000 adults—would newly enroll in KanCare if the state expanded Medicaid up to 138 percent of the federal poverty level, as provided under the ACA.

During 2017, both the U.S. House of Representatives and U.S. Senate proposed and voted on a handful of bills to repeal or modify various provisions of the ACA, including Medicaid funding and the expansion option. However, no bill has yet passed. In 2018, GOP leadership likely will resume their efforts. Despite this uncertainty, expansion advocates in Kansas have indicated they intend to pursue expansion again in 2018.

2017 Health-Related Committee Chairs

SENATE COMMITTEE CHAIRS

Financial Institutions and Insurance
Jeff Longbine (R)

Public Health and Welfare
Vicki Schmidt (R)

HOUSE COMMITTEE CHAIRS

Insurance
Jene Vickrey (R)

Health and Human Services
Dan Hawkins (R)

Social Services Budget
Brenda Landwehr (R)

Child Welfare System Task Force

House Substitute for Senate Bill (SB) 126, enacted during the 2017 session, directed the secretary of the Kansas Department for Children and Families (DCF) to establish a Child Welfare System Task Force, including several working groups, to study the child welfare system in the state. The 20-member task force, chaired by Sen. Vicki Schmidt, includes vice chair Rep. Steve Alford, Senators Barbara Bollier and Laura Kelly and Representatives Linda Gallagher and Jarrod Ousley. Other members include individuals representing the judicial branch, law enforcement, social welfare, child advocates, DCF officials and foster care contractors.

The Task Force—charged with studying the administration of child welfare by DCF, protective services, family preservation, reintegration, foster care and permanency placement—began meeting in August and will submit to the Legislature a preliminary progress report by January 8, 2018, and a final report on or before January 14, 2019. The report is expected to recommend changes to current laws, rules and regulations, and child welfare system processes that will result in improved safety and well-being for children in the Kansas child welfare system.

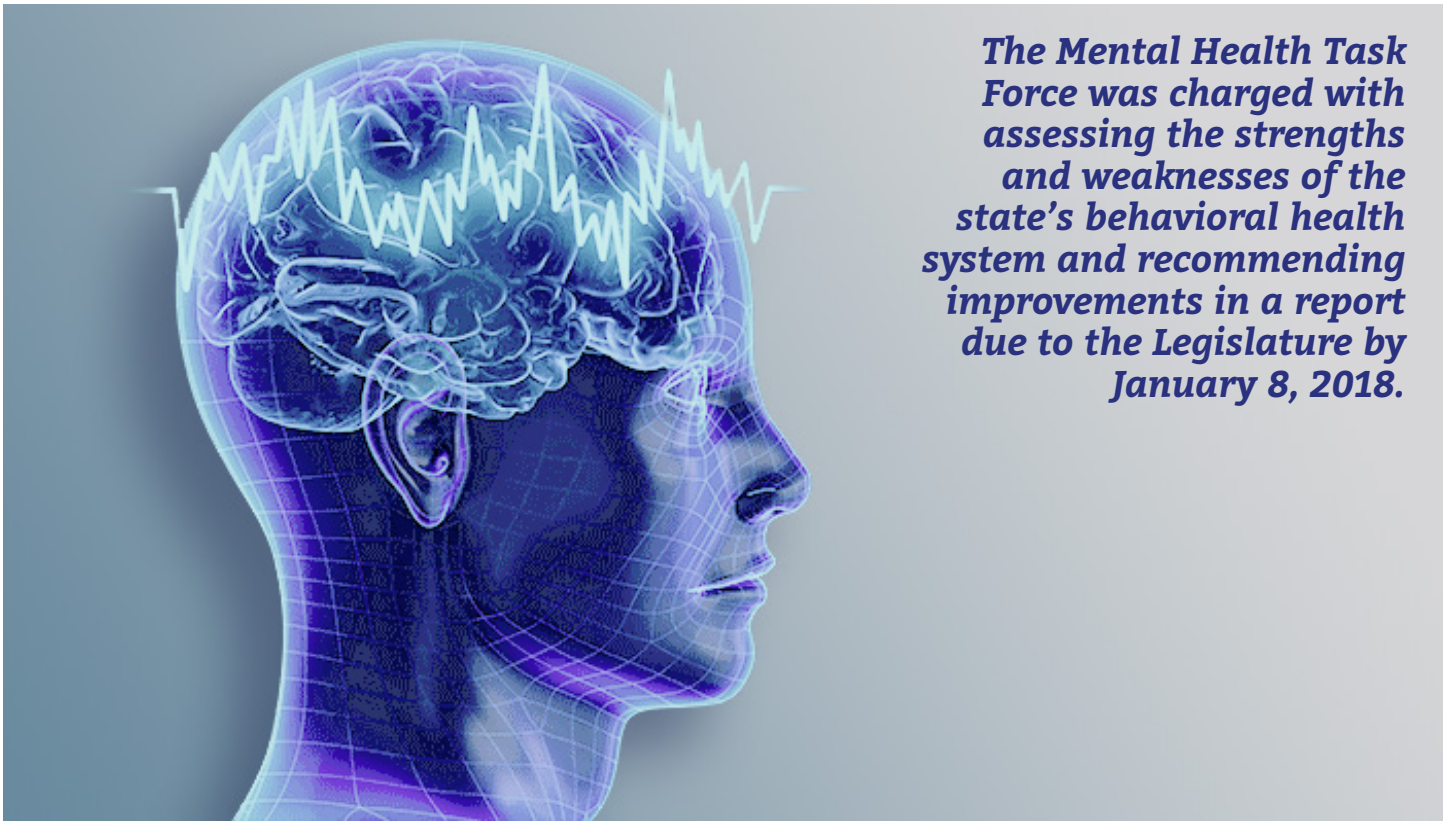
In addition to reviewing the initial findings of the task force, legislators also will begin working with the newly appointed secretary of DCF, Gina Meier-Hummel, who is a member of the Task Force. She was nominated to fill the role of secretary by Lt. Gov. Jeff Colyer on November 21 and started work with DCF on December 1 following the retirement of former secretary Phyllis Gilmore.

Behavioral Health/ Osawatomie State Hospital

Mental Health Task Force

The budget passed by the 2017 Legislature included a proviso directing KDADS to establish a task force to review the behavioral health system in Kansas. Comprised of 11 members, the Mental Health Task Force was charged with assessing the strengths and weaknesses of the state's current behavioral health system and making recommendations for improvements in a report due to the Legislature by January 8, 2018. The recommendations are expected to include a strategy focused on the most effective ways to deliver services for individuals of all ages, the availability of crisis stabilization centers, the maximization of federal and other funding sources for services, the certification of Osawatomie State Hospital (OSH), and options related to privatizing services.

A progress report to the Legislature is expected to include recommended improvements regarding the safety and well-being of children in the Kansas child welfare system, including changes to current laws, rules and regulations, and child welfare system processes.



The Mental Health Task Force was charged with assessing the strengths and weaknesses of the state's behavioral health system and recommending improvements in a report due to the Legislature by January 8, 2018.

Osawatomie State Hospital

After federal inspections of OSH in May, August and November, KDADS was advised on December 18, 2017, that CMS had recertified 60 beds in the Adair Acute Care unit at Osawatomie State Hospital. OSH had been operating below its 206-bed capacity since mid-2015 and losing about $1 million per month in Medicare and other federal reimbursements since the hospital was decertified in December 2015, when CMS cited inadequate staffing and "immediate and serious threat to patient safety."

In August, KDADS Secretary Tim Keck announced a plan for the state to demolish and rebuild OSH and to contract with a private company to operate the hospital at a lower cost than what the state is currently spending. In response to a request for proposals, one bidder—Correct Care Recovery Solutions (CCRS), a Tennessee-based company—submitted a proposal to create a public-private partnership to operate OSH. In 2016, and again in 2017, legislators included provisions in enacted legislation that prohibit KDADS or any state agency from taking any action to outsource or privatize any state facility providing mental health services without specific authorization by the Legislature. Secretary Keck estimated that construction and operation of OSH could cost $100 million to $175 million. He has advised members of the Legislative Budget Committee that he intends to have a plan for building a new facility to present to legislators in January 2018.

Opioids

During the 12 months ending April 30, 2017, the U.S. Centers for Disease Control and Prevention (CDC) has provisionally reported that more than 65,000 people nationally, including 300 Kansans, died from drug overdoses. For the five-year period from 2012 to 2016, more than 1,500 Kansans died from drug poisoning, with over 45 percent of deaths involving heroin or a pharmaceutical opioid (e.g., oxycodone, methadone, fentanyl, hydrocodone). Forty-six percent of the victims of drug poisoning deaths were age 35–54. During 2013 and 2014, more than 100,000 Kansans misused prescription pain relievers. The number of deaths due to opioid analgesics in Kansas increased threefold from 1999 to 2013.

During the 2017 session, legislators unanimously passed HB 2217, which created standards for the use and administration of medications known as "emergency opioid antagonists" such as Naloxone, by first responders and other bystanders, including family members, friends, caregivers or others in a position to help a person who is experiencing an opioid overdose. In 2018, in order to avoid or

minimize a growing opioid problem in Kansas, legislators may decide to take a look at legislation enacted by other states to address the opioid epidemic, such as:

- Enhancing prescription monitoring programs;
- Enacting a seven-day limit on prescriptions, consistent with the CDC's 2016 recommendation;
- Requiring health care providers to take continuing education on addiction, pain management and palliative care;
- Requiring additional reporting of opioid overdoses and usage of antagonists in the state;
- Ensuring the availability of addiction treatment options;
- Enacting new sentencing guidelines for non-violent drug offenders to get them into treatment rather than incarceration; and
- Creating a formal task force to study and make recommendations to state officials about a coordinated response to the opioid problem.

1,500
Kansans have died from drug poisoning between 2012 and 2016, with more than 45 percent involving a pharmaceutical opioid or heroin.

Marijuana

Five bills addressing legalization of both medical and recreational marijuana were introduced during the 2017 session, but only two received a hearing. Substitute for SB 155, the *Cannabis Compassion and Care Act*, would have eliminated criminal and professional penalties for non-intoxicating cannabinoid medicine. It passed out of the Senate Federal and State Affairs Committee but did not receive a vote in the chamber. The Legislature has considered several medical marijuana bills since 2015 and will likely be presented with one or more bills during the 2018 session.

In September, the Kansas Democrats announced that full legalization of marijuana, both for medical and recreational use, would be part of the party's platform for 2018. Twenty-nine states and the District of Columbia currently have laws legalizing marijuana in some form, but only seven states and the District of Columbia have legalized marijuana for recreational use.

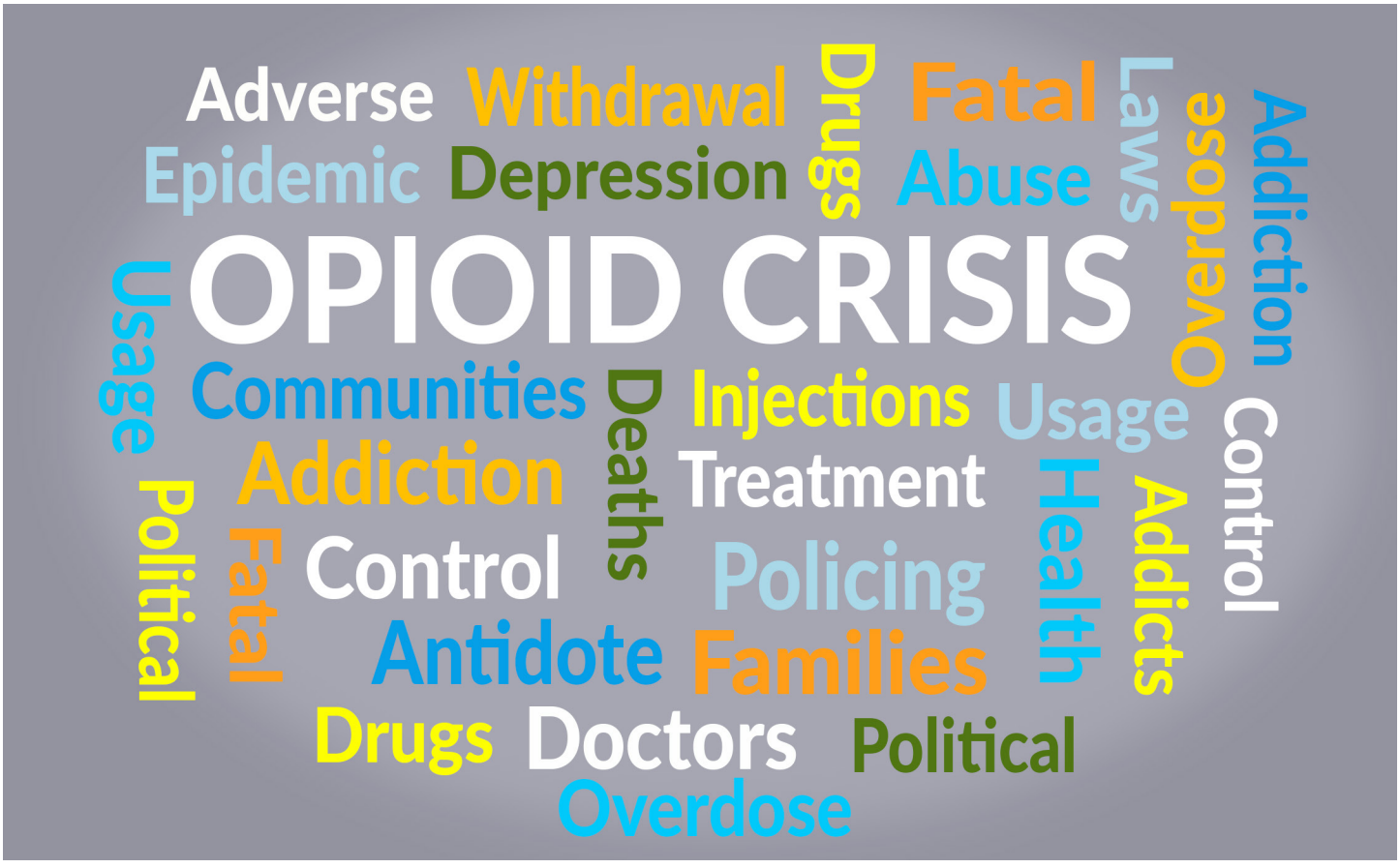
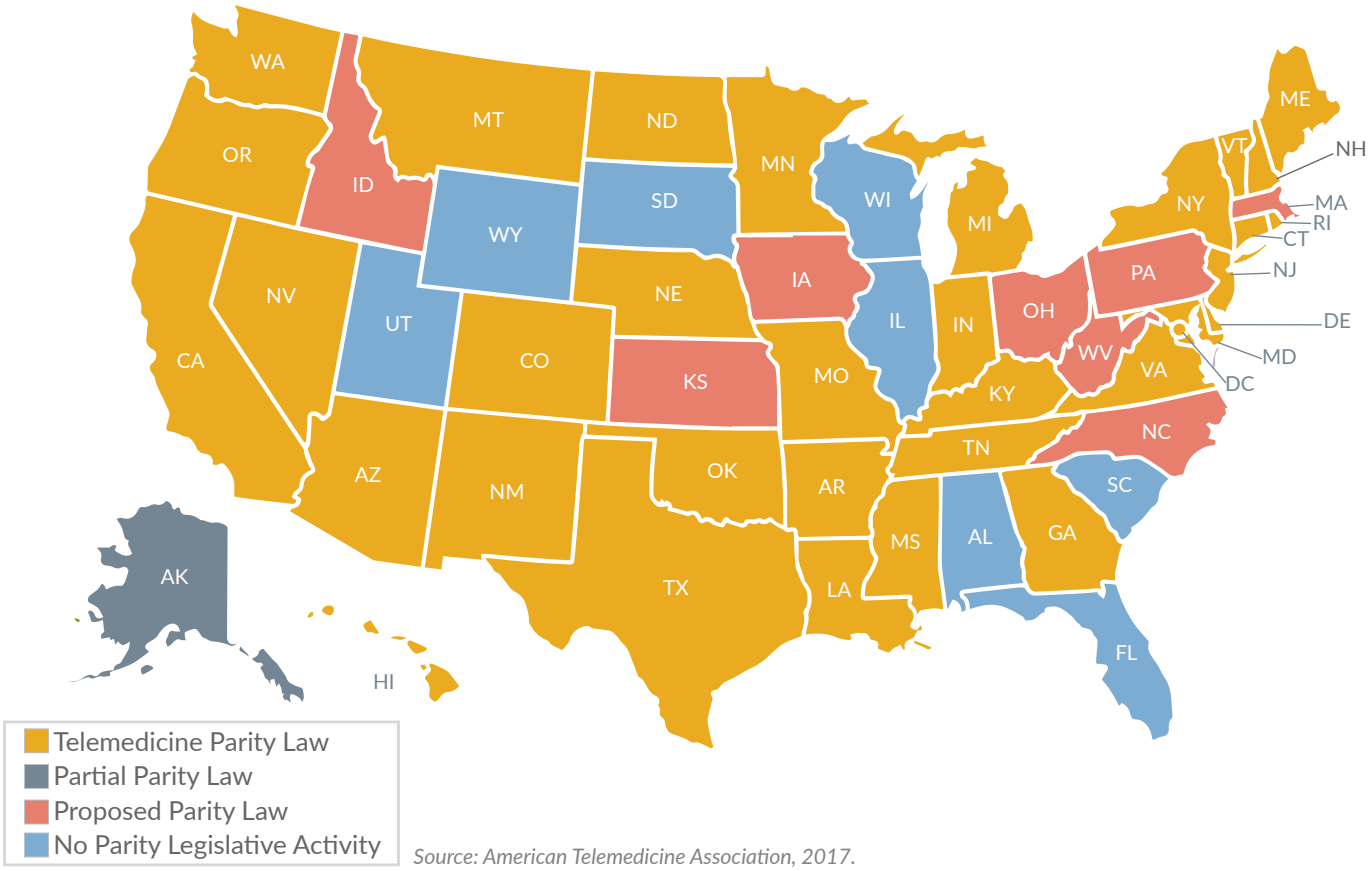


Figure 1. **States with Parity Laws for Private Insurance Coverage of Telemedicine (2017)**



Source: American Telemedicine Association, 2017.

Telemedicine/Telehealth

The House Health and Human Services committee considered two bills in 2017 related to telemedicine/telehealth—HB 2206 and HB 2254. Both bills received a hearing but no vote. In October 2017, an interim Special Committee on Health held two days of hearings on the two bills. The committee was chaired by Rep. Dan Hawkins and included Senators Vicki Schmidt, Barbara Bollier and Laura Kelly and Representatives Susan Concannon, Jim Kelly and Monica Murnan. More than 50 presenters submitted testimony over the two days, and many encouraged legislators to again consider the two bills in 2018. Conferees also encouraged legislators to address:

- Private insurance coverage and reimbursement policies for telemedicine/telehealth services;
- Standardized telemedicine/telehealth terms and definitions;
- Regulations for telepharmacy, and specifically the prescribing of opioids and other controlled substances via telemedicine;
- Licensing and practice standards for telemedicine providers; and
- Confidentiality of patient records and appropriate documentation of telemedicine encounters.

Following the Special Committee's hearings, chairman Dan Hawkins stated that the House Health and Human Services Committee (also chaired by Rep. Hawkins) will consider a bill during the 2018 session to make insurance coverage mandatory for telemedicine. Thirty-six states and the District of Columbia have laws that address reimbursement policies for private payers, including four that border Kansas. During the Special Committee hearings, representatives of two Kansas insurers testified in opposition to adoption of "payment parity," which would require payers to reimburse telemedicine providers the same amount that is paid to providers for in-person services.

36
states and the District of Columbia have laws that address reimbursement policies for private payers of telemedicine.

Other Health-Related Issues

Legislators also may decide to take another look at bills introduced in 2017, including scope of authority and licensing for dental therapists, taxes on cigarettes and food, palliative care and vaccination requirements.

Federal Issues

Children's Health Insurance Program

Legislators also will be watching progress of key federal programs in early 2018. Funding authorization for the Children's Health Insurance Program (CHIP), a joint state-federal partnership that provides health insurance to low-income children whose family incomes exceed Medicaid limits, expired at the end of September 2017. Just before breaking for the winter holidays, Congress passed a short-term extension that will provide funding for CHIP through March 2018, but a longer-term extension will not be debated until Congress returns in January.

While CHIP has bipartisan support in Congress, determining how a longer-term extension will be paid for has delayed action. States that have "separate" CHIP programs, including Kansas, have policy options if funding is not ultimately reauthorized. They may terminate their CHIP programs, transition children to other coverage options (including Medicaid), or impose enrollment caps. For more information about the options, see KHI's September 2017 Issue Brief, *Reauthorizing the Children's Health Insurance Program*.

While KDHE indicated in November 2017 that it would move to transition the approximately 38,000 CHIP-enrolled children in Kansas to Medicaid if federal funding for CHIP is exhausted, there would be a budget effect, as the federal match for Medicaid is lower than it is for CHIP. KDHE estimated the additional cost to the state budget would total nearly $38 million in the current fiscal year and $53 million in Fiscal Year 2019.

Community Health Center Funding

The continuing resolution passed by Congress also included partial-year funding for the Community Health Center Fund (CHCF). The fund provides more than 70 percent of all federal support for Community Health Centers (CHCs). Like CHIP, its funding had expired at the end of September 2017, but the partial extension in the continuing resolution provides funding for the CHCF through March 2018. In 2016, Kansas CHCs provided care for more than 200,000 Kansans.

Federal Health Reform

Congress is expected to continue to debate repeal, replacement or modification of the ACA during 2018, including proposals to drastically alter federal funding for Medicaid and give states greater flexibility to make changes in their health insurance markets. Kansas legislators may get an opportunity to consider proposals for a Kansas solution to health reform, as recent comments from CMS officials and congressional proposals to address rising premiums in ACA marketplace plans suggest that states may see increased legislative flexibility and funding to help them craft new state-based approaches to providing insurance coverage and access to care for their citizens.

ABOUT THE ISSUE BRIEF
This brief is based on work done by Linda J. Sheppard, J.D., and Hina B. Shah, M.P.H. It is available online at khi.org/policy/article/18-01.

KANSAS HEALTH INSTITUTE
The Kansas Health Institute delivers credible information and research enabling policy leaders to make informed health policy decisions that enhance their effectiveness as champions for a healthier Kansas. The Kansas Health Institute is a nonprofit, nonpartisan health policy and research organization based in Topeka that was established in 1995 with a multiyear grant from the Kansas Health Foundation.

212 SW 8th Avenue | Suite 300
Topeka, Kansas | 66603-3936
785.233.5443
khi.org
/KHIorg
@KHIorg
@khiorg