KANSAS HEALTH INSTITUTE

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ISSUE BRIEF

JANUARY 2017

2017 KANSAS LEGISLATIVE PREVIEW

Anticipating key health policy themes

Introduction

The 2017 legislative session will mark the first year of a two-year cycle. While issues from previous sessions—such as the status of the state's psychiatric hospitals, Medicaid expansion and medical marijuana—will likely resurface, all will be in the form of new bills. Dozens of new faces in the Capitol also mean the Legislature itself will have a new character.

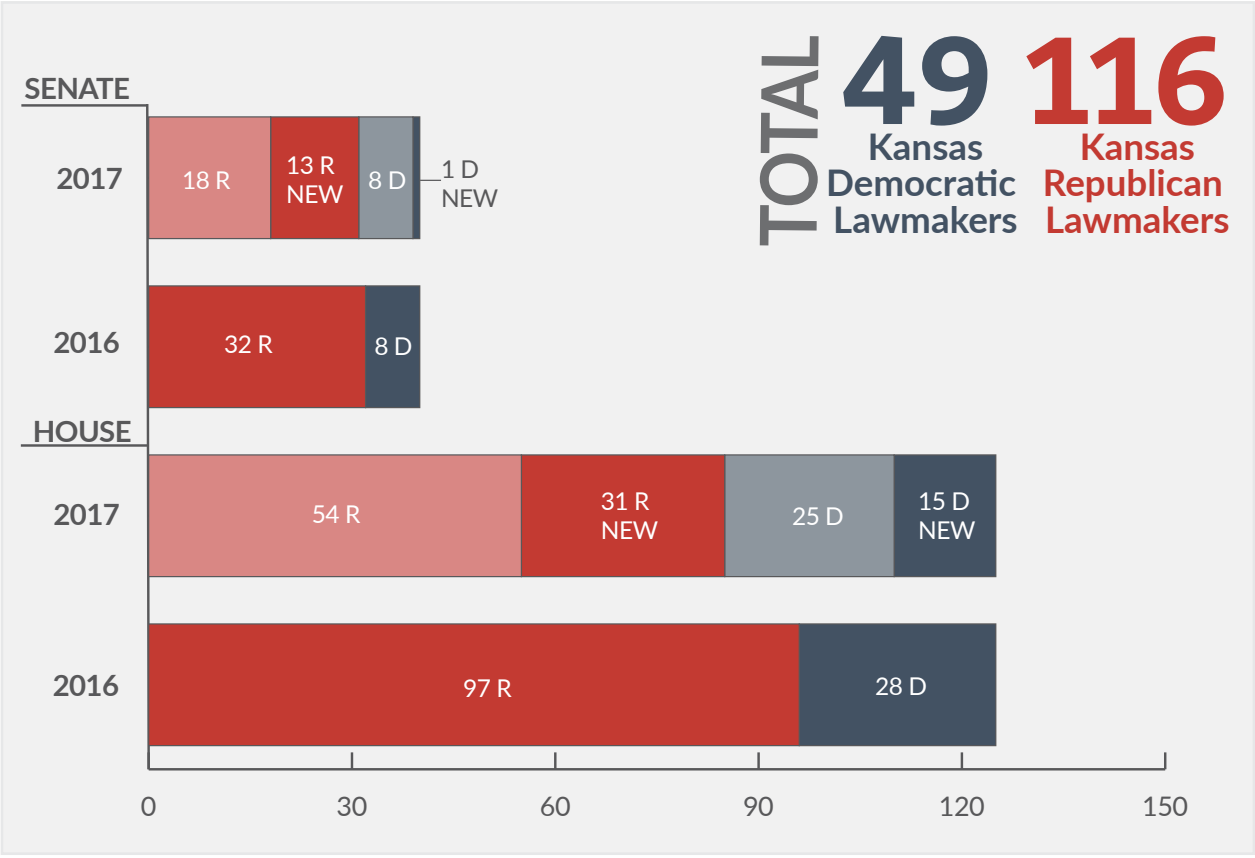
As a result of the general election in November 2016, the Kansas Senate has gone from 32 Republicans and eight Democrats to 31 Republicans and nine Democrats. Fourteen of the senators are new, although five of them were in the Kansas House in 2016. The Kansas House went from 97 Republicans and 28 Democrats to 85 Republicans and 40 Democrats. Forty-six of the representatives are new for 2017, but six of them have previously served in the House. (These numbers include the recent announcement of Rep. Marvin Kleeb's retirement on Jan. 10 and the election of his successor, Abraham Rafie.)

KanCare

During the 2017 session, legislators will have the opportunity to debate and respond to a number of issues related to the current and future operation of the Kansas Medicaid program, known as KanCare.

KanCare 2.0

Although the initial three-year term of state contracts for the three KanCare managed care organizations (MCOs) ended December 31, 2015, the MCOs have continued to operate under an optional two-year extension of the original term of their contracts.

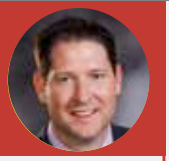
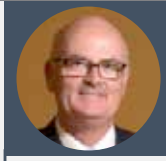


It was anticipated that the Kansas Department of Health and Environment (KDHE) would issue a new request for proposals (RFP) before the end of 2016 to select the MCOs that would be operating KanCare beginning on January 1, 2018. However, on November 18, 2016—during a meeting of the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and the KanCare Oversight Committee—KDHE officials announced that the renewal process for KanCare was being placed on hold and the RFP was "delayed indefinitely." On December 16, 2016, Lt. Governor Jeff Colyer announced that the state had renewed the existing MCO contracts and would not request new bids until late 2017. Colyer also stated these changes were the result of uncertainty regarding what the election of Donald Trump as president and Republican control of Congress might mean for state Medicaid programs.

Kansas Senate 2017 Leadership

Majority President (Republicans) Susan Wagle 	 **Minority Leader (Democrats)** Anthony Hensley
Vice President: Jeff Longbine	**Assistant Leader:** Laura Kelly
Majority Leader: Jim Denning	**Whip:** Oletha Faust-Goudeau
Assistant Leader: Vicki Schmidt	**Agenda Chair:** Marci Francisco
Whip: Elaine Bowers	**Caucus Chair:** Tom Hawk

Kansas House 2017 Leadership

Majority Speaker of the House (Republicans) Ron Ryckman, Jr. 	 **Minority Leader (Democrats)** Jim Ward
Speaker Pro Tem: Scott Schwab	**Assistant Leader:** Stan Frownfelter
Majority Leader: Don Hineman	**Whip:** Ed Trimmer
Assistant Leader: Tom Phillips	**Caucus Chair:** Barbara Ballard
Whip: Kent Thompson	**Agenda Chair:** Brandon Whipple
Caucus Chair: Susan Concannon	**Policy Chair:** Adam Lusker

KanCare Performance

In fiscal year (FY) 2016, Medicaid and the Children's Health Insurance Program (CHIP) covered a monthly average of about 426,000 people at an annual cost of almost $3.4 billion to the state. In Kansas, 25.1 percent of all Medicaid and CHIP enrollees are seniors or people with disabilities, but this combined population incurs 70 percent of total state spending for these programs. Children and families, including children in CHIP, account for approximately 75 percent of Medicaid and CHIP enrollees and incur 30 percent of state spending. In FY 2016, annual Medicaid and CHIP spending averaged $2,925 per pregnant woman, child or family member, compared to $23,863 per enrollee with a disability and $15,540 per senior enrollee.

During the November 2016 KanCare Oversight Committee meeting, legislators heard from a number of KanCare beneficiaries and providers regarding concerns about the administration of benefits and the timing and processing of provider reimbursements. They also heard from a representative of Leavitt Partners, a health policy consulting firm engaged by the Kansas Hospital Association, the Kansas Association for the Medically Underserved, and the Kansas Medical Society, to conduct an assessment and analysis of KanCare. The firm concluded the program had "not met its original rationale and commitments."

KDHE countered by reporting a number of positive quality and outcomes measures. The KanCare Oversight Committee responded by recommending

specific program changes, and it is likely that legislators will be asked to consider additional action to respond to the concerns expressed by beneficiaries and providers.

During the November meeting, legislators also continued to hear reports of lengthy delays in the processing of Medicaid applications, specifically those for individuals admitted to skilled nursing facilities. KDHE reported in September that a backlog of applications was being resolved and had been reduced significantly over the summer. The KanCare Oversight Committee asked the agency to provide an updated report regarding the number of pending nursing facility applications.

Budget Cuts

In November, KanCare Oversight Committee members also heard from health care providers about the impact of the 4-percent cut in reimbursements that was made by Governor Sam Brownback in May 2016 to help balance the state budget. Legislators heard concerns that the cuts had shifted costs from the state to providers, and that the effect could be a loss of providers willing to accept KanCare members.

The KanCare Oversight Committee recommended reversing the 4-percent cuts. However, revenue projections by the Consensus Revenue Estimating (CRE) group in early November indicating a $346 million shortfall in revenues for FY 2017 and an additional drop in FY 2018 revenues may complicate the Legislature's efforts to restore the payments.

Medicaid Expansion

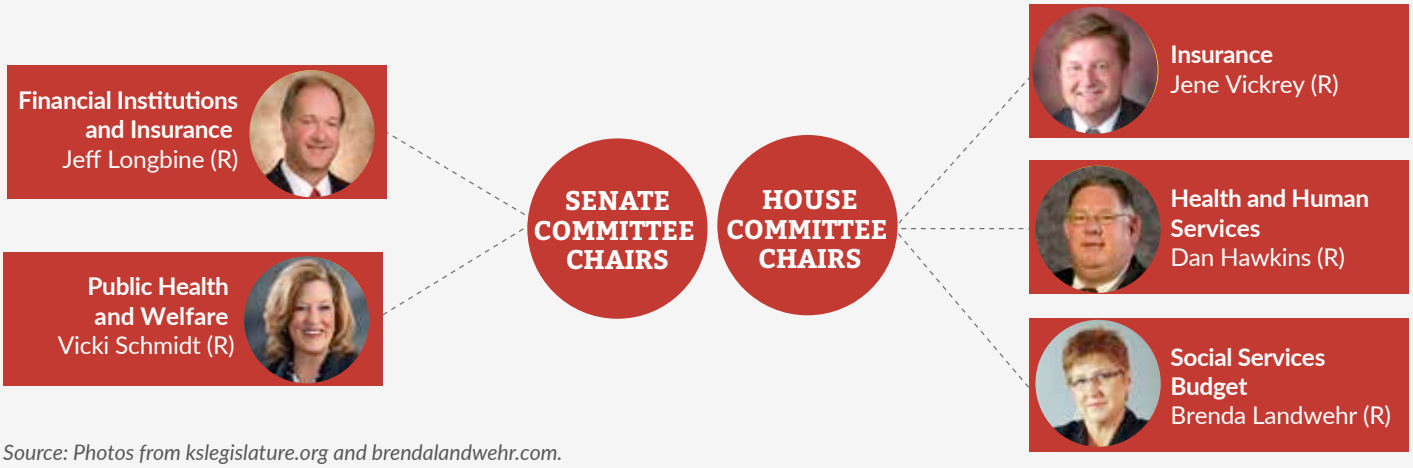
KHI estimates 152,000 people—including 98,000 adults—would newly enroll in KanCare if the state expanded Medicaid up to 138 percent of the federal poverty level, as provided under the Affordable Care Act (ACA). During the 2016 session, the Kansas Hospital Association introduced two identical bills, entitled "KanCare Bridge to a Healthy Kansas Program," in the House and Senate. A 2015 study by Manatt, Phelps and Phillips, LLP, had suggested the state could generate new revenue and savings to offset the cost of expansion. However, neither bill received a hearing.

Since June 2016, the Alliance for a Healthy Kansas—a nonprofit entity backed by five Kansas health foundations and more than 70 organizations that support the expansion of Medicaid—has conducted more than 20 community meetings across the state with the stated goal of educating Kansans about the "economic and health benefits" of expansion. Expansion advocates have also been conducting a series of regional meetings with newly elected legislators.

Recent polls conducted by the Kansas Hospital Association and the Docking Institute of Public Affairs have found that more than 60 percent of Kansans support expansion of KanCare, particularly if it is budget-neutral or revenue-generating.

Given recent announcements regarding the state's budget shortfalls, along with the outcome of the November 2016 elections, it is not clear how the 2017 Legislature may respond to the introduction of new Medicaid expansion bills. Both President-elect Donald Trump and Republicans, who now control both chambers of Congress, have stated their intent to repeal the ACA. The U.S. House Republican plan issued June 2016,

2017 Health-Related Committee Chairs



Source: Photos from kslegislature.org and brendalandwehr.com.

"A Better Way," would remove expansion as an option for states that have not yet expanded, and proposed a gradual reduction in the enhanced match rate for states that have already expanded.

Adding to the uncertainty of Medicaid expansion are Republican proposals to transition federal funding for Medicaid to block grants or a per capita allotment approach, and the announcement of President-elect Trump's selection of Rep. Tom Price for Secretary of Health and Human Services and Seema Verma as the new head of CMS. Price supports block grants to states and has also proposed requiring "able-bodied" applicants to meet work requirements in order to receive benefits.

Verma, who was instrumental in the design and implementation of Medicaid expansion in Indiana, has previously spoken about the need for states to have greater flexibility in the operation of their Medicaid programs, which could lead to new expansion models or other approaches to Medicaid in non-expansion states such as Kansas.

State Mental Health Hospitals

Following the decertification of Osawatomie State Hospital (OSH)—the state-owned and operated facility providing care for adults diagnosed with psychiatric disorders—by CMS in December 2015, officials with the Kansas Department of Aging and Disability Services (KDADS) reported in November that the issues that led to decertification have been addressed. KDADS Acting Secretary Tim Keck reported during a recent KanCare Oversight Committee meeting that facility upgrades have been completed, staffing has been improved, and OSH is ready for inspection by CMS officials, the final step for recertification. Secretary Keck also stated that, for now, KDADS has elected to try for recertification of only 60 beds at OSH, although he hasn't ruled out seeking recertification of the other 146 beds.

KDADS posted a RFP in November to privatize the operation of OSH. The RFP seeks proposals for a five-year contract to operate OSH, with an option to extend it for three additional years. During the 2016 session, the Legislature passed SB 449, which prohibits KDADS from entering into any agreement or action to privatize the operations of OSH without prior authorization by the Legislature.

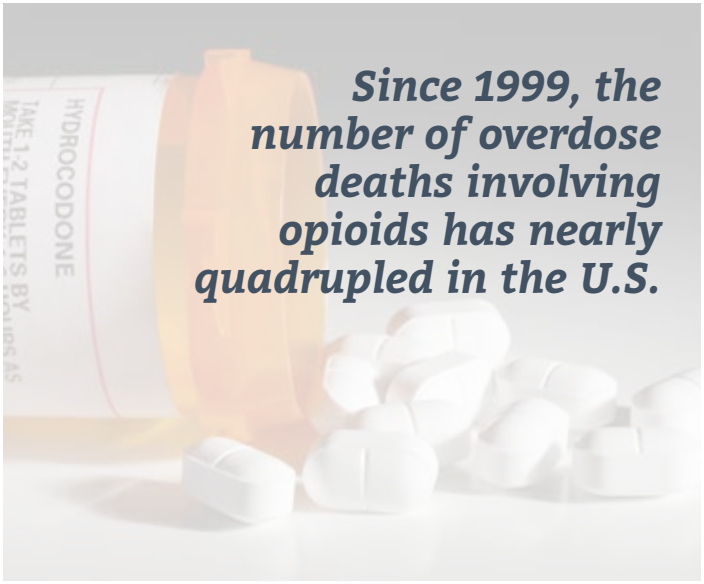
Prescription Painkillers/Opioid Addiction

In 2014, more than 47,000 people in the United States died from drug overdoses, more than any year on record. At least half of all drug overdose deaths involve a prescription opioid, and since 1999, the number of overdose deaths involving opioids (including heroin and prescription opioid pain relievers, such as hydrocodone, oxycodone, morphine and codeine) nearly quadrupled. From 2000 to 2014, nearly half a million people died from drug overdoses. Almost two million Americans abused or were dependent on prescription opioids in 2014.

Although Kansas is not currently experiencing the consequences of the opioid epidemic to the same extent as other states, during 2013–2014, more than 100,000 Kansans misused prescription pain relievers. The number of hospitalizations due to acute poisoning from drugs increased threefold from 1999 to 2009, and the number of deaths due to opioid analgesics also increased threefold from 1999 to 2013.

The acute drug poisoning rate in Kansas for 2009–2013 was 10.6 per 100,000 people, which falls below the Healthy People 2020 goal of 11.3. However, looking at regions in Kansas, the rates vary widely from a low of 5.7 per 100,000 in Southwest Kansas to a high of 13.4 per 100,000 in Southeast Kansas. Of the acute poisonings, the most common specified drug category was opioid analgesics, which constituted 41.1 percent (606) of deaths.

Men had a higher likelihood of dying than women from acute drug poisoning with 11.6 deaths per 100,000 for



Since 1999, the number of overdose deaths involving opioids has nearly quadrupled in the U.S.

Kansas males and 9.6 deaths per 100,000 Kansas females. While still below the national average, the rate of overdose deaths among people age 12–24 in Kansas has quadrupled since 1999. In March 2016, health centers in Wichita, Pittsburg and Garden City were awarded a total of $1.4 million in grants from the U.S. Department of Health and Human Services to support their treatment programs for opioid abuse.

In 2016, more than 30 states enacted legislation to address aspects of the opioid epidemic, including:

- Laws strengthening prescription drug monitoring programs; and
- Laws regarding the sale, dispensing, possession and administration of opioid "rescue drugs" such as naloxone, and immunity for providers of these drugs.

Some states have also made naloxone available without a prescription to further increase access and have enacted Good Samaritan laws to allow people to seek help for themselves or another experiencing an overdose without prosecution.

To date, Kansas has not enacted any naloxone access or overdose Good Samaritan laws, but should Kansas lawmakers choose to address this growing issue, there are a number of policy options available from other states to learn from.

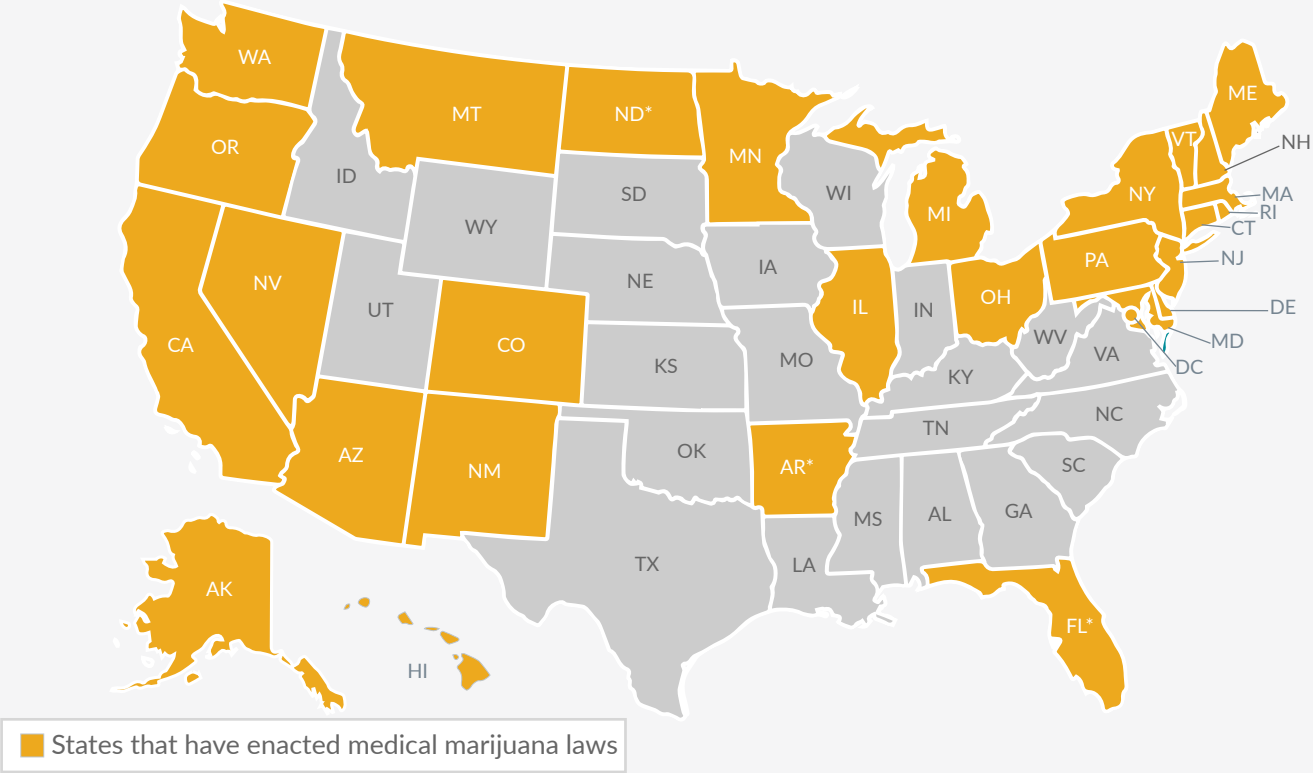
Medical Marijuana

During both the 2015 and 2016 sessions, Kansas legislators considered and debated several bills related to legalizing marijuana for medical use. In 2016, bills introduced in both the House and the Senate received hearings and passed out of committee but failed to make it to the governor's desk for signature.

Bills that have provided for more restrictive use, such as the use of hemp oil only (rather than the whole plant) have received the most positive response from legislators. It is anticipated that one or more medical marijuana bills will be introduced in 2017.

In November 2016, voters in Arkansas, Florida and North Dakota approved ballot measures for the legalization of marijuana for medical use, bringing the total number of states that allow medical marijuana to 29, including the District of Columbia. With the recent announcement of

Figure 1. **Medical Marijuana Laws in the United States, 2016**



Note: * In November 2016, voters in Arkansas, Florida and North Dakota approved ballot measures for the legalization of marijuana for medical use.

Source: Information compiled by KHI from National Conference of State Legislatures, 2016.

President-elect Trump's selection of Alabama Sen. Jeff Sessions—an opponent of legalized marijuana—for U.S. Attorney General, questions have arisen regarding how the federal government will respond to the legalization of marijuana use in the states.

Telemedicine/Telehealth

During the 2016 session, the Kansas Legislature established the Interstate Medical Licensure Compact (IMLC), which will establish a streamlined licensing process for physicians interested in practicing medicine in multiple states. Legislators saw the IMLC as a way to increase the number of physicians who could potentially provide telemedicine services to Kansans, particularly in rural areas.

States like Kansas that struggle with a shortage of medical professionals have acted to expand the use of telemedicine and telehealth, including enactment of "telehealth parity laws." These laws require telehealth service providers to be reimbursed equivalent to reimbursements for in-person health services. In the absence of these types of parity laws, providers are less likely to implement telehealth options for their patients.

In Kansas, teams of primary care clinicians and other health care professionals, linked with expert specialists at the University of Kansas Medical Center (KUMC), are currently participating in weekly TeleECHO clinics, which allow the participants to conduct "virtual grand rounds" along with mentoring and patient case presentations. The success of these programs, such as the Project ECHO model at KUMC, may generate interest among legislators to seek ways to expand the use of telehealth modeled after the wide variety of alternatives that have been implemented across the country.

The Rural Healthcare Working Group, chaired by Lt. Governor Jeff Colyer, met through 2016 to explore problems in health services delivery in rural Kansas. The group is compiling a set of policy options to address those challenges, and some options may require legislation. The list is expected to include strategies to expand the use of telehealth, make it easier for rural hospitals and other providers to innovate, improve access to behavioral health services, and address workforce shortages across a wide range of provider types.

Scope of Authority/Practice/Licensing

It is anticipated that legislation related to dental therapists and advanced practice registered nurses (APRNs) may be introduced in 2017 to respond to shortages of both dental and primary care providers in some parts of the state.

Legislation concerning APRNs was introduced in 2015 and received a hearing but died in committee in June 2016. In the past, opponents of such legislation have expressed concerns regarding the quality of care provided by mid-level practitioners if not under direct supervision of dentists or physicians. Twenty-two states have state practice and licensure laws that allow all nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments, and prescribe medications under the exclusive licensure authority of the state board of nursing. This is the model recommended by the Institute of Medicine and National Council of State Boards of Nursing.

In 2016, the Kansas Dental Project introduced SB 413 in the Senate Public Health and Welfare Committee, but it received no hearing and died in committee. In 2009, Minnesota became the first state to authorize the licensing of dental therapists (DTs), with a requirement that they primarily treat underserved patients. In conjunction with the enactment of the law, the Minnesota Legislature directed its Board of Dentistry to consult with two state agencies to evaluate the impact of the DTs on the delivery of and access to dental services in the state. In a February 2014 report entitled *Early Impacts of Dental Therapists in Minnesota*, the Minnesota Department of

Health and the Board of Dentistry reported on the experiences of the DTs practicing in the state, including reactions from the patients they served. In addition to Minnesota, two other states, Alaska and Maine, have enacted mid-level dental practitioner models.

Prescription Drug Costs

After a sharp spike in spending on prescription drugs beginning in 2014 and a number of high-profile price increases on popular drugs for the treatment of diabetes and hepatitis C in 2016, the cost of prescription drugs has become a national conversation.

Several states have attempted to stall the rise in costs through cost-saving efforts such as increased price transparency, rebate agreements with pharmaceutical companies for Medicaid programs, and a variety of utilization management practices (e.g., step therapy, cost-sharing, preferred drug lists, limits on quantities dispensed). States have also employed pharmacy benefit managers (PBMs) to assist in the implementation of a variety of cost-saving strategies. Kansas has implemented strategies for KanCare including step therapy, a preferred drug list, and a mandatory 90-day supply provision for maintenance medications.

Though the high cost of pharmaceuticals is widely discussed, concrete policy action is extremely difficult to accomplish. In November, California voters rejected Proposition 61, a closely watched proposal in the national conversation on the high cost of pharmaceuticals. Under this ballot measure—which sought to rein in drug costs paid by the state for millions of state employees and retirees, prisoners, and low-income people—certain state health programs would have been required to negotiate the same prices for prescription drugs as the U.S. Department of Veteran Affairs, which are typically deeply discounted. Drug companies spent more than $109 million to oppose the measure and argued that it would have reduced access to medicines and resulted in price increases for others, including veterans. The measure also was opposed by veterans' groups and the California Medical Association.

In addition to actions taken by states, prescription drug costs were addressed by both Donald Trump and Hillary Clinton leading up to the November elections. Both Trump and Clinton proposed allowing consumers to import prescription drugs from foreign nations with safety and quality standards similar to the U.S. Since the election, President-elect Trump has not announced any plans to address prescription drug costs in the near term. However, the potential repeal of the ACA and any subsequent replacement proposals could include steps to curb these rising costs.

Budget

On November 10, 2016, the Consensus Revenue Estimating (CRE) group projected a $346 million shortfall in the state's revenues for the remainder of the current fiscal year, which ends on June 30, 2017, and a decrease of $444 million in projected

revenues for fiscal year 2018, which begins on July 1, 2017. Following the CRE announcement, Budget Director Shawn Sullivan stated that no immediate spending cuts would be made, but that Governor Brownback would be presenting a rescission bill to the Legislature in January. The governor will also be submitting the new two-year budget to legislators in the first weeks of the session.

The Human Services Consensus Caseloads (*Figure 2*) process projected that total spending on social service programs, including welfare, foster care, KanCare and other medical assistance, will rise by $147 million for the remainder of the current fiscal year, but with just $2 million of that increase paid from state general funds. Beginning in the FY 2018 budget, all KanCare expenditures will be included in the budget of KDHE. The Kansas Department for Aging and Disability Services and the Department of Corrections will retain responsibility for their respective programs' policies and performance.

Figure 2. **Human Services Consensus Caseloads, in millions**

Human Services Caseload Estimates	Fund*	FY 2017	FY 2018	FY 2019
Department of Children and Families (DCF): Temporary Assistance to Families	SGF	$0.3	$0.1	$0.1
	AF	$15.3	$14.4	$13.5
DCF: Foster Care Contract	SGF	$99.7	$103.2	$109.0
	AF	$162.9	$167.1	$174.0
Department of Corrections (DOC): KanCare	SGF	$1.4	–	–
	AF	$3.2	–	–
Kansas Department of Health and Environment (KDHE): KanCare	SGF	$644.5	$925.0	$1,085.0
	AF	$2,080.0	$2,635.0	$2,677.4
Kansas Department of Aging and Disability Services (KDADS): KanCare	SGF	$243.6	–	–
	AF	$666.7	–	–
KDADS: Non-KanCare	SGF	$24.0	$20.5	$20.5
	AF	$35.7	$26.8	$26.8
TOTALS	SGF	**$1,013.5**	**$1,048.8**	**$1,214.6**
	AF	**$2,963.8**	**$2,843.4**	**$2,891.8**

Note: *SGF= State General Fund, AF= All Funds. Some numbers may not sum to totals because of rounding.

Source: Kansas Legislative Research Department, November 10, 2016.

ABOUT THE ISSUE BRIEF

This brief is based on work done by Carlie J. Houchen, M.P.H., Linda J. Sheppard, J.D., and Kari M. Bruffett. It is available online at khi.org/policy/article/17-02.

KANSAS HEALTH INSTITUTE

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