Bob St. Peter: Hello, I'm Bob St. Peter. I'm a pediatrician and the former president of the Kansas Health Institute. Today is May 5, 2026, and I'm in Topeka, Kansas, to interview Kari Bruffett. Kari is a lifelong Kansan, has had many different roles in health policy in the state, and currently is the president of Kansas Health Institute. Thank you for being here today, Kari.

Kari Bruffett: Thanks, Bob. Thanks for inviting me.

BSP: Looking forward to it. This interview is part of the Kansas Oral History Project, exploring health issues in Kansas. The Kansas Oral History Project is a nonprofit corporation that collects and preserves oral histories of Kansans. This series is supported by donations from generous individuals and a grant from the United Methodist Health Ministry Fund. Our videographer is former State Representative Dave Heinemann. Kari, again, thanks for being here.

KB: You bet. Looking forward to it.

BSP: So, tell me a little bit about your roots, your family history in Kansas. Where are you from?

KB: I grew up in western Kansas. I was actually born in the Panama Canal Zone. My dad was in the Air Force. But you're very close when you say "a lifelong Kansan" because from about age nine months on, I grew up in western Kansas. My parents were teachers. I grew up a lot of my life in Oberlin, Kansas, in the northwest corner of the state. If people aren't familiar with that, that is close to Nebraska and not too far from Colorado.

When I was in high school, my dad got a job in Victoria, which is, if folks aren't familiar with it, it's a little town not too far from Hays, but with a very well-known church, the Cathedral of the Plains.

BSP: I warned you, I was going to say, so you got the Cathedral of the Plains in Victoria, and we have a beautiful church in Damar, Kansas, where my family is from also. We've debated which is more remarkable.

KB: Yes, they're both beautiful, and that's one of the great things about some of the small towns in Kansas, some incredible historical sites there. So, I grew up in Victoria, went to Fort Hays. My first job out of college was a newspaper reporter. When I think about looking back on my life and my work in health policy, probably when I was working for the *University Leader* at Fort Hays, I wasn't thinking that someday I'd be working at the Kansas Health Institute, but in a way, the path makes sense, really thinking about how policies impact people, whether that's health policy or really any sort of governmental policy. That's the kind of work that is important to understanding how policy impacts health. So, it really set the stage for me.

BSP: That's awesome. You told me one time that your background as a journalist was attractive to Jerry Moran, I believe he liked to hire journalists?

KB: Nancy Kassebaum, actually. I worked for three years at the newspaper in Paola, the *Miami County Republic,* which was at that time a twice-weekly newspaper. It was always competing for

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the awards for the non-daily papers with the Kansas Newspaper Association. I got to cover county government and the hospital board, and I'll age myself a little bit, did interviews around health reform back when it was called "Hillarycare" instead of Obamacare in the nineties.

One of the experiences I got to have was spending the larger part of a day interviewing Senator Kassebaum when she was on a visit back to Miami County and going around from place to place. I somehow talked myself into or was granted the ability to ride with her from place to place. Mike Harper, her state director, was taking her to each location. I got to talk to her about every topic under the sun. She was really generous with her time. We talked quite a bit about health policy and health reform at that time.

Not so many months later, there was an opening in her office for a legislative assistant, and I was very fortunate that she liked to hire people with journalism backgrounds because I think—I won't put words in her mouth, but I always thought probably a common denominator with those folks is that they can take a lot of complex information and boil it down to some key questions. Sometimes in the heat of a policy debate, that's what you need.

I learned so much in DC working for Senator Kassebaum. I was there her last two years in office, and then she decided not to run again. But the timing was really interesting because when just a few months after I moved to Washington DC to start working for her, that's when the big Contract with America election happened, and the Republicans took control of both chambers, and she became chair of what was then the Senate Labor and Human Resources Committee, now the HELP Committee. So, I got to work on a lot of health policy work that maybe I didn't even expect when I was going out there to work on budget and appropriations work.

I got to work on education policy as well. I was in Senator Kassebaum's office when HIPAA was passed. However, I always say to my friends in health care, I wasn't really very directly involved in it, the development of HIPAA, for those who either appreciate it or also find some of it challenging. But it was a great accomplishment, and I remember at the time the arguments about whether it was going to be called Kennedy-Kassebaum or Kassebaum-Kennedy, as legislation because it was so important, the legislation at the time. But I was very peripherally involved—my involvement was as a budget analyst. I was really looking at impacts, budget impacts of various policies, health and education policy.

BSP: Was the CHIP program authorized at that period of time when you were in Senator Kassebaum's office?

KB: That wasn't anything that I worked on. After she did not run for office again, I did get the opportunity to work for Jerry Moran in his first term in the House as his first legislative director. That's where I really got engaged in health policy, particularly around rural health. At the time he was very involved, and I know he still is very involved, with the Rural Health Caucus. That was some of my introduction to some of the very specific rural health policy work as well.

BSP: What are some of the things that you learned from working at the federal legislative level, both in the House and the Senate, that you carried with you through your career maybe that you find useful in what you're doing now?

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KB: First of all, I think it's hugely important work, and policy makers want to know how the impact of the federal policy, what that impact is in their districts or in their states that they're coming from. So, hearing from hospitals and doctors and community members and advocates in their communities was always really important. It's not only important for the elected officials, but for their staff, too. A lot of staff in legislative offices, some come with a lot of experience and background. Some, like me, were pretty fresh and green. So, we really wanted to hear how federal policy was impacting or could impact really important health issues in Kansas.

So, one of the things I learned is that developing those relationships, not just with a member of Congress but with their staff can make a big difference and help drive policy decisions. I learned a lot from people coming from the Kansas Hospital Association or from individual health care providers when I was working particularly on the rural health policy issues. So, I keep that in mind, too, to remember that it's not always about, "Hey, can I get a chance to meet with a member to talk about this issue?" but the staff who do incredibly important work are really important to build those relationships and share information with as well.

BSP: Yes. What do you think is different—are there differences between the way Congress works and the staff and the members interact, and the members interact with each other now compared to years ago when you were working there?

KB: Yes, I think I could probably make some assumptions based upon watching the news and that sort of thing. There certainly was a lot of collegiality, particularly in the Senate, the House as well, but particularly in the Senate. A lot of the rules of the Senate kind of enforced that, and it was in the House, too. There were very specific and purposeful bipartisan coalitions in both Chambers that worked on policy together. I think that still happens to some extent, but I do think there was maybe more of a premium placed on some of the bipartisan legislation that would get passed than appears to be the case today. You know, not working there directly and really only having sort of the really Kansas specific view, I probably have not a full complete picture of how everything operates. There's still a lot of bipartisan legislation that moves through Congress as well. But I think there was a particular premium back in the day on getting a "Dear Colleague" letter that had a good number of signatures from Republican members and Democratic members to really move forward a policy issue.

BSP: Another thing about that period of time, there weren't a lot of women in Congress when you were working for Senator Kassebaum.

KB: Yes.

BSP: Talk about that. How did she approach that? How did you think it affected her interaction with her peers.

KB: She had incredible respect among her peers. I remember working on a project at one point where there was, I think it was a German publication that wanted an article about Senator Kassebaum from the perspective of a woman in government, and she kind of resisted that framing a little bit. She talked about it a little bit, but it wasn't—for her, it wasn't about being a

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representative of women in Congress but instead was just demonstrating that women in those roles can negotiate just as toughly but also bring in different perspectives.

When people ask me that, I always think back on that experience where there was an initial draft written up like "Here's some suggestions of ways maybe (I) as a former reporter (think) that you could really emphasize your historic position in Congress," and again, she sort of resisted it and was so much more practical. She's also very self-effacing. So, I think that was probably part of it as well.

BSP: I think I remember in her office that she had a sign that had the layout of the Senate floor and had all the male symbols, ninety-nine of them, and one female symbol in that picture. Am I remembering that right?

KB: There were a few more women by the time I was working for her.

BSP: Okay. So, at one point, she might have been the only one there.

KB: Yes.

BSP: I know you've kept in touch with a group of the people that worked with you back then. Tell me a little bit about that, the relationships and what sort of brought you guys together and kept you together all these years.

KB: You bet. Some folks have come back to Kansas who worked for her at the time I worked there. Some are still in DC. I remember when I, maybe the second or third year I was working in DC, one of the folks in Senator Kassebaum's office said, "You know, about the time about three or four years in is when you decide whether you're going to stay in DC or you're going to head back to Kansas," because that's sort of the point where you think all your experience is more valuable in DC than it is in Kansas.

I don't know if that's really true because I certainly know folks who've spent more time there and also came back to their home states or home communities. But I see there's definitely some folks who are career in DC, who still serve and think about their role as Kansans, but then also have grown into national roles as well.

BSP: Was your role always in DC?

KB: Yes.

BSP: You spent those years there.

KB: Yes, in DC.

BSP: You obviously would make trips back with the member back to the state.

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KB: Occasionally and worked very closely with the state-based staff as well. I really enjoyed my time working for her and for Jerry. It was a very different experience, because Senator Kassebaum was at the end of a long and illustrious career. She had a lot of positions that were very well established. I learned so much in that role, and I learned a lot from Jerry in a different way. It was his first term. For many issues, he was navigating them for the first time. So, how did he do that? They both had a lot of similarities in that they put a high premium on listening to Kansans, seeking out voices, maybe even voices that might have a different opinion than their starting position might be, to hear and respect those points of view. And then for Jerry, it was maybe the first time he was voting on a specific piece of legislation to make sure he had heard from a lot of different Kansans about that. That was part of our role as staff was really to make sure that we had representative voices informing policy decisions.

BSP: And you mentioned his particular interest in rural health, giving you the exposure to those issues. We'll come back to talk about some of those rural health issues, too.

KB: Yes.

BSP: At some point, you decided to come back to Kansas. Tell me about that transition.

KB: It was maybe that point that my colleague had said, it was about four years. I really did miss Kansas and my family, but I still wanted to be involved in policy. I wasn't really specifically in health policy. I was Jerry's legislative director. So, I worked in rural health but did a lot of other things as well.

I first came back to Kansas and worked at Koch Industries. I worked both in policy but some with the foundations, a couple of the foundations. It was a pretty short time there.

BSP: Were you in Wichita?

KB: I was in Wichita. I learned a lot there as well. But then had the opportunity—I was recruited to get more in the politics side of things from the policy side before, and I worked for four years for the Kansas Republican Party as the executive director back when Mark Parkinson was the chairman of the Kansas Republican Party, later a Democratic governor. So, different times.

BSP: We have to unpack some of that. You're working on the Hill.

KB: Yes.

BSP: You come back and spend a short time working for private sector. Obviously, the Koch family is very involved in politics. Was that some connection to the job?

KB: Not necessarily.

BSP: How did you land that position with the Republican Party?

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KB: You know, I don't entirely know. I know some of my colleagues and friends from my time in DC knew Mark and had suggested that maybe I'd be somebody to talk to. I think that was the connection. So, some of those networks of folks, both from Jerry's office and from Senator Kassebaum's office. At the time, I think that's where it came from. It was kind of out of the blue when I got the call. It was a great opportunity.

BSP: Yes. Any lessons that you carried forward from that period of time with your career working in the political side of the policy world?

KB: First of all, I enjoyed working with people and working with folks particularly who were maybe first-time candidates or people deciding whether they wanted to run for office and how they would do that. It was an interesting experience to see where people had started and kind of the journey of thinking about how do you want to run for office and put yourself out there to be a candidate and then what it may mean many years and decades later about how their leadership has evolved.

So, I enjoyed that time. It was a time like a lot of times in party politics when there's differences of opinion between wings of a party. Those differences are different now than they were then. What I always enjoyed about it was trying to hear people from where they were, understand that not everybody was going to have the same perspective even within a party, let alone within all of society or all of Kansas, but even within that party and try to understand their perspective and give them grace about where they're coming from and try to figure out if there's some ways to work together. I found that enjoyable, challenging sometimes, but also enjoyable about the work. But I missed policy though. I definitely missed the policy work because obviously working for a party organization is very focused on helping support candidates and elections.

BSP: But understanding what motivates candidates who eventually end up in office and how they approach issues, I'm sure that was very helpful to you in your subsequent roles that we'll talk a little bit about.

KB: Yes.

BSP: Tell me about the transition from that role to your next role at KU.

KB: After Mark didn't run for the party chairmanship again, I had an opportunity to work at the University of Kansas—what was then the University of Kansas Hospital Authority. It was the University of Kansas Hospital, but I think my paycheck said Hospital Authority, now known as the University of Kansas Health System. It was not so many years—now I'm forgetting the exact year when KU Hospital had become a Hospital Authority, had converted from a true state-funded hospital to this quasi-independent, but still governmental entity. The real experiment that that was and [it was] both a leap of faith but also a good investment in policy that the policymakers made to allow the hospital to strike out—I won't say on its own—but strike out differently.

So, a lot of the work in the early years was really helping tell that story and then build the opportunities for the hospital to really grow and leverage that increased independence, the ability

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to act when opportunities and needs were there instead of always waiting for the full legislative funding cycles and so on. I remember floors of that hospital, the walls hadn't been updated since the Carter administration, maybe some beds—I hope you're interviewing somebody from the KU hospital system because they're going to have it fresher in their mind about this history, but there was some equipment and certainly physical space and infrastructure that really needed to be dealt with, and it was, but that was all part of really a change in the culture of the health system, the hospital, as well. So, I get to work on the policy side of that, not the hospital administration side. The credit for the turn-around is definitely the folks who were providing the care and managing the hospital.

BSP: When you went to KU Hospital, was Irene Cumming still there?

KB: She was.

BSP: Okay. She was still there.

KB: My time overlapped with both Irene Cumming, as the CEO, and then Bob Page when he became the president and CEO. He was a VP when I first started.

BSP: It really has been a remarkable transformation.

KB: Yes, incredible.

BSP: Of a hospital and a health system, lots of challenges, not just with the physical infrastructure.

KB: Yes, financial challenges.

BSP: Some quality-of-care issues that really challenged the hospital and I think led to this transformation and now a twenty-five to thirty-year evolution to a leading academic health center it's been remarkable. Tell me a little bit—you were there a number of years. Tell me about what were some of the really important things that happened early in that transition for the health system for the hospital.

KB: Certainly—and again, by the time I was there, that transition had already been well underway, but I do think the ability to look at opportunities and needs that the community had and be able to—building, if you look at the physical infrastructure of what the hospital was and the health system was when I first started, which was really mainly the base of the old hospital building, which is still sort of the main hospital, but now has additional floors and additional buildings, and it is now much more collaborative between the Hospital Authority and the medical center, the medical school side as well, which I think was a challenge for a few years, really, the balance of the hospital's needs and the health system's needs, and the needs also of the medical center and the medical school.

BSP: And it was under the leadership of a single person at one point in time.

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KB: Right.

BSP: Before this transition happened.

KB: Right. I think some of that transition made it a little bit more challenging perception-wise, both on campus, but it also provided opportunities, not just growth for growth's sake, but for actually meeting needs in the community—great work to tell the story I think helped really—some of the challenges also led to really good opportunities for increased collaboration and sort of the unification—unification is maybe not the right word, but I really think of the health system now as it is, a health system, where for a while, it was seen as almost two-tracked, not by everybody. My email address was at kumed.edu, even though we were part of the health system or the Hospital Authority. So, there was sometimes some confusion about "What's the hospital? What's the medical school? What's the med center?" I think a lot of that has melted away, I think to the great advantage for the health system and for the faculty who are the physician staff and for everybody.

BSP: I think those challenges are very typical of institutions that have gone through that transition.

KB: Yes.

BSP: It's not unique. KU's experience wasn't unique, but that separation between the hospital and the medical school, and how the other health profession schools, and even getting privileges, faculty getting privileges at the hospital, all these sorts of things that have to play out. You've mentioned a couple of times the physical structure. This is a question. I expect this is part of the story. Getting money for the hospital when it was under the full control of the state probably had a lot of politics and legislative sort of input around when they would be able to raise capital and that sort of thing? Was that one of the big changes that happened with the transition, that the hospital could access capital easier?

KB: Maybe this is too simple, but that story about the—it's more of an illustration than a technical explanation, but the story about the beds that were from the Carter administration or the walls that will had the same carpet on from probably at least that time were because they were subject to—the hospital at that time was subject to appropriation cycles and overall state budget pressure, not only what was on the hospital, but on the overall state budget as well. So, there was a new opportunity for the hospital to acquire capital, raise more money directly, raise money from charitable sources as well to be able to support the work, not that that didn't happen before because it absolutely was happening before for a state entity, but it provided a different level of independence that allowed them to be responsive, but also be able to make some investments that were harder to do when you're dependent upon a year-to-year appropriation cycle.

BSP: In your role with government affairs for a growing and transforming health system, what were some of the issues that you dealt with?

KB: It was interesting. We worked with both state policymakers and federal policy makers because a lot of the policy issues impacted one or the other or both or were impacted by one or

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the other or both. An example, one's definitely more federal was the 340B drug pricing program. That's always a federal policy.

BSP: Give the nutshell of what that is.

KB: It's basically discounted pharmacy costs for certain kinds of facilities, at the time, primarily safety-net hospitals. There are things you have to do.

BSP: And it's still a major issue in the legislature right now.

KB: Now it's actually become more of a state issue as well. Historically, and this is I think still the case, people will correct me if I'm wrong, if you run a 340B program, those medications are kept completely separate and distinct from the medications from others as well. There's an administrative responsibility that goes along with it, but it actually does have, create savings as well. Some of the current discussion is always "Who benefits from those savings the most?" I think that's some of the discussion, both at the federal and state level, but that was part of the work we worked on pretty regularly to make sure that was something that at the federal level, that was maintained because that was important for the patients that were served by the health system.

BSP: Before we move on to other topics, I'm going to take a little bit of a policy nerd dive on 340B.

KB: I'll let you go from now on.

BSP: No, there are questions. One of the challenges—and we'll talk about Medicaid expansion later, but the facilities that are eligible for this program to get the reduced-price prescription drugs, they have to provide a certain amount of care to Medicaid patients, unreimbursed care, that sort of thing. As Kansas being one of the states that has not expanded Medicaid, the number of people, and therefore the share of patients that many hospital are caring for with Medicaid is actually going down, and there are several hospitals that are crossing that threshold from being eligible for the 340B program to not being eligible because their Medicaid share is going down. I think that's an interesting, unexpected ripple effect of the Medicaid expansion question.

KB: I know—we're going to skip ahead—I did end up later working in state government, including in a Medicaid agency, and that was an issue even sort of prior to some of the key decisions around Medicaid expansion where that was impacting hospitals. I think another program that I worked on when I worked at KU Health System and is still an issue right now is disproportionate share hospital payments.

BSP: Explain briefly what that is.

KB: Again, it's really intended for additional funding. It's set on a cap at the federal level, by state, that is available for hospitals that serve, as the name makes it sound, a disproportionate share of uninsured or uncompensated or undercompensated care. So, that in part, when the

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Affordable Care Act passed, there was— part of the pay-fors included a planned reduction over time in the disproportionate share hospital payments.

BSP: The idea that more people would have insurance.

KB: There would be less uncompensated care. Those cuts have a few times been sort of moved forward and in subsequent years, when the Supreme Court made the decision to expand Medicaid-- a *decision* to expand Medicaid not just a policy happening-- so that it's different by every state, there are different impacts for every state about what those changes could look like. So, disproportionate share hospital payments, we were talking about it even before the Affordable Care Act passed. That had passed while I was working at the health system. It was always a big issue, and it became an even bigger issue. We also had a big policy issue that I think is still really relevant that we worked on at the time was about graduate medical education and about both the number of slots, basically the positions for training physicians in their residency positions that were funded by Medicare, both the number of slots and also the payments that teaching hospitals would receive, both for the direct cost of graduate medical education and indirect costs.

There were some historical factors, and you know this pretty well, there are historical factors that are calculated that haven't changed—at least at the time hadn't changed in many, many deca– that would establish some hospitals and health systems getting a lot less for these indirect costs than other health systems because of historical costs, not because of even current costs.

BSP: Very large differences in how much a hospital would get for training a resident in Kansas City versus New York or something like that.

KB: Right. We worked on both sides of that, both the number of physicians, then also what those payments looked like. We tried to work with others, both providers and states, and going back to DSH [Disproportionate Share Hospital], also there's states that are considered low DSH states, or very low DSH states, because there are formulas that vary by state that impact—at the time that were impacting how much those caps were in each state, and then from the graduate medical education, it's more by institution, but those were also varied. We tried to build coalitions with others that had similar situations. So, that's some of the stuff I worked on at KU.

BSP: That's fascinating. Let me ask a little bit about the educational mission of KU Hospital. Most people when they think of a hospital, they probably think of "Am I going to get good quality of care? How much is it going to cost me? Are they in my insurance plan?" that sort of thing. But one of the major missions of a teaching hospital—at the time, the only medical school in the state of Kansas, is training physicians. We'll talk a little bit later about the challenge around work force issues in our state. How did a hospital—where most people would think of as primarily providing medical care—how did it address those issues and its responsibility around training and education of physicians?

KB: Maybe rephrase that.

BSP: It's not what I think most people would think of as part of running a hospital.

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KB: Yes.

BSP: Was that handled separately by a whole group of different people?

KB: It's part of the way that care is provided. Certainly, in my time there, I received care at KU Hospital. There definitely were times where you would be meeting with a provider, and they'd say, "Would it be okay if we bring in this group of residents to be able to observe?" Sometimes, it would be just one resident maybe providing care for you directly with a teaching faculty. But one of the things that's different in a teaching hospital that can lead to these indirect costs of graduate medical education, this is probably where you're going, is that sometimes that means it takes more time, not that it takes too much time, it takes a little more time because not only are you providing care for the people and really high-quality care, you're also training the next generation of physicians and other medical professionals to be able to provide that care, too.

Some of those indirect costs can sometimes, and I don't know if this is always the case, but can sometimes, maybe different tests get administered because this is also a way to teach the physicians as well, the resident physicians as well. So, there are some of those costs that mean that maybe some things just take a little bit more time—I don't mean to say in a way that impacts the quality of care like a delay in care. I don't mean that at all, but it may mean a physician is taking this time, cares for the patient, goes out, and is also working with the physicians in training and the residents before they go to the next room.

BSP: Some of those embedded costs that are not explicitly paid for, the hospitals have to have some way to get reimbursed.

BSP: Okay. So, the training and teaching of physicians doesn't happen just in academic medical centers, right?

KB: Right, and I think there's—we'll probably talk about it later as well when we're talking about workforce—there's more and more effort to try to distribute some of the training throughout in different locations—really solid research, for example, that shows that where somebody does their residency, particularly if it's combined with where they've done their primary part of medical school and then they do the residency, if it's in a rural setting or includes a rural setting, they're more likely to be serving in a rural community.

BSP: In the long run.

KB: So, that could be a rural hospital or at least a non-academic medical center hospital working with a teaching hospital, but it can be other settings, too, like health centers as well.

BSP: The Wichita Campus Med School was operating when you were at KU.

KB: Absolutely.

BSP: The Salina campus was not.

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KB: It wasn't.

BSP: So, there's the innovation there of opening a medical school campus in Salina.

KB: Absolutely. Then there always were the opportunities for rural rotations as well. Those continue. I think even more of an effort to try and do that, to be able to help build up a physician workforce in Kansas, rural Kansas, particularly.

BSP: Just to wrap up sort of thinking about the policy issues you dealt with when you were at the largest health system in the state, I think the first time that I met you, we were in a meeting at KU with a bunch of the senior folks there, talking about—

KB: Which was not me at the time. I just happened to be at the meeting. I was not senior folk.

BSP: We were talking about county health rankings, this concept of what's the role of the hospital, especially a large teaching hospital, in thinking about community health and community health indicators. Tell me how a health system thinks about that, and why they have their policy person in the room sitting in on that conversation.

KB: Well, I probably invited myself or heard about it and wanted to come in and learn about it, but, yes, I was at—I don't remember what year it was, but I know we were at the Westwood campus for KU Hospital, and you and Gianfranco came, Gianfranco Pezzino, were talking about county health rankings and particularly in Wyandotte County, which is where KU Hospital is located.

BSP: Which was the lowest ranked county in the state of Kansas in that first county health ranking.

KB: Right, and the mayor at the time was asking folks, Mayor Reardon, was saying, "Hey, well, what are we going to do?" and we need to reach out and really engage, not just the health care community, but absolutely the health care community, to be part of the discussion. And, as you know, county health rankings are not just "How good it your hospital in your area?" In fact, it's not that at all. It really is all these other factors that are impacting health, influencing health.

I remember either you or Gianfranco [Pezzino]were going through some of the areas where Wyandotte County faced particular challenges, and some of it was—maybe I remember seatbelt use or some things like that as well, certainly a lot of other socioeconomic factors, too. I remember looking through as you were talking, going, "How can a hospital—we're here to provide care when people walk in the door, and they need the best quality of care that they can get, and maybe at the most critical time of their lives from across the state, including absolutely in Wyandotte County." I think at the time I listened, and I thought, "I'm going to go back and try and figure out what would the ranking be if it was just about health care factors, the access to health care factors" and so on.

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But I think things have evolved a lot, not just in my thinking. It absolutely has evolved in my thinking, but with KU Health System and so many other of the health systems and hospitals in Kansas where the role of hospitals not just as health care providers, but also as members of their community and large employers in their communities and thinking about the overall health of their community, not just the quality of their health care, but a lot of these other factors. So it's really important.

I remember a county commissioner at the time came and talked to us about investing and trying to get more sidewalks put in some of the neighborhoods around the KU Health System, around the hospital because some of those neighborhoods just had no sidewalks at all. It was just the streets, and people were walking on the streets. They wanted more ability to have exercise and safety and so on in the community. Those were maybe more emerging ideas not so very long ago really, but now things are really embraced by not just KU Health System but many other hospitals as well. It can't be only hospitals. I will absolutely acknowledge that. Hospitals aren't always reimbursed really for that kind of work.

BSP: Your reaction I think was very common at the time.

KB: I bet.

BSP: Which is "What in the world does a hospital have to do with what happens outside the walls of the facility?"

KB: Right.

BSP: One of the examples, and I know we've talked about this. You've dealt with this a lot. You take a patient with congestive heart failure that shows up in the hospital, gets great care, looks great, is all tuned up and ready to go back home. They get home, and they don't have transportation to get to their follow-up. They don't have healthy food accessible to them. They're isolated socially. They don't have financial and educational resources to really manage their health. Well, what happens to that patient? They end up back in the hospital with congestive heart failure.

So, figuring out how to engage hospitals along with the community and all the community partners is now a much more common—what we haven't figured out yet is how to build the right reimbursement system to really make that work.

KB: Absolutely. Things like accountable care organizations I think in part were sort of to incent that, but the level of effectiveness and whether the incentives meet the need is still in progress.

BSP: I remember that meeting well. It sounds like you do, too.

KB: I hope I didn't look too skeptical while you were talking. I was really interested, I promise.

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BSP: I think it was another sort of growth in our thinking about health and how to improve health in the state. Maybe I'll jump to that broader health in the state question now, and then we'll come back to other experiences.

KB: You bet.

BSP: We talked about the county health ranking. That's a project that KHI [Kansas Health Institute] did, originally looking at counties within the state. It then became a national program that the Robert Wood Johnson Foundation ran, looking at county health rankings in every state. But the United Health Foundation for many years has put out a state health ranking, comparing the health ranking of one state compared to the other. You know this very well. You guys have been doing a lot of work on this, but Kansas at one point had a high rating of being the 8th healthiest rated state back in 1991, not that long ago. That's in the timeframe we're talking about here.

KB: That's when I graduated from college.

BSP: Now the ranking for Kansas has fallen to as low as 33 and now has bounced back up a little bit towards around 27. But lots of questions about rankings—why are rankings helpful if they are helpful?

KB: I think there's a few ways that rankings can be helpful. I'll reflect on county health rankings, but also apply this to America's Health Rankings, the state health rankings. I'll start out with what they maybe shouldn't be used for. If they're primarily competitive or made to feel like, "We're not as good as our neighboring state or county," that probably isn't the best way to use rankings. It probably isn't very motivational, particularly when some of the things that counties or states need to do to change the trajectory of their ranking aren't going to happen overnight. But it can bring together—it can create a need. It can create the idea that—I know that sounds contradictory, but it can create some energy and momentum around a need. By thinking of it as not just one measure that you could assign to "This is one entity that's responsible for this measure," but really the wide range of factors that influence health, it hopefully also helps people see their work or how their work can be connected.

BSP: How it's all connected.

KB: Yes. So, it's not going to be just a hospital. It's not just going to be a legislature or a governor that can turn things around. It's going to really require—or a mayor or a county commission either. It will require all of those folks as well as employers and people who are advocates for people of the community, providers, not just health care providers, but other service providers as well are part of it.

So, the rankings can be helpful for maybe creating the sense of "Hey, we need to build our team to be able to improve our relative position." Rankings don't always mean if your ranking falls, it doesn't always mean that your overall performance in a certain measure has reduced. It means that you've lost ground compared to your neighboring state or county. But it can mean that you actually just have also worsening health outcomes, actual ones. It's an indicator of, I've used this

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in another setting, I think sort of a warning indicator on your car. You'd better pay attention when you see that change, particularly if it's—gosh, you saw an overnight change from 8 to 31 overnight, you'd be really concerned. If it takes a few decades, a couple decades to get there, maybe it sort of slips by until you start looking at it as ranking and see your relative position.

I think one of the things that the Kansas Health Foundation by focusing on America's Health Rankings and trying to get Kansas to not just turn things around but maybe lead the nation in health focused on is that it took something like saying not only did Kansas fall a lot, but it actually fell the furthest.

BSP: Of any other state.

KB: From any other state. That's a sort of wake-up moment. I think the rankings can be a wake-up call. But then individual measures within the rankings, even if you're a higher-ranking county that's maybe usually first or second or third or a state that's higher ranking, there's still individual measures that absolutely impact health, factors that impact health where we can improve, both relative to other states or communities, but also in our own work.

Some of these measures, as you know, in America's Health Rankings, they include things like occupational fatalities. In Kansas, that's sometimes been a challenge in part because we have a lot of employment in the agriculture industry and in transportation, so in trucking, and that sort of thing as well, and construction. There are opportunities, maybe folks who are employers in construction don't think of themselves as "We're involved in Kansas's health ranking," but absolutely, that's part of the work. So, we had a convening last year with some folks from the Department of Labor and the Farm Bureau as well, thinking about what they're doing to really focus on occupational health and safety in Kansas because that's also part of health.

BSP: Yes. I know you guy took a hard look at those rankings, tried to understand, talked to people all over the state, tried to understand what we think can explain this decline that Kansas has seen, which, as you said, has been a steeper decline than any other state has experienced over that time.

KB: And you might be talking to somebody later who's one of the authors—I won't step into his stories too much—but, yes, we looked at it and said, "Well, what can we say?" We know there's many, many—you can do a mathematical analysis and say, "Here's"—and we have absolutely looked at some of the measures that really have driven Kansas's changing position, which, by the way, Kansas has had for the last three years an improvement in the health ranking.

BSP: Each year.

KB: Which is the first time there's three years in a row since they started doing it of improvement, but just like one, two at a time. We could do a lot of mathematical analysis, but there's so many factors. We knew there's a story behind those factors. So, this was a process called the Delphi study. Not to be too technical, but (we) basically surveyed or reached out to more than 100 people and had more than 100 people participate, about 100 people participate in identifying—we laid out the challenge that you just described, the change in Kansas's health

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ranking and then asked them, "What do you think is causing it? And what are the concerns we have, what are the priorities that could turn things around?"

The first wave was just collecting all of that input from 100 folks. We reached out across sectors, not just in health, and not just in public health. We reached out to business and policymakers as well. I will say that we had the highest response, so it's probably absolutely affected the results, from folks who work in health and in public health. But we sent that net out far and wide. And then the second round, after we got all of those responses and kind of grouped them into key themes, we asked folks to prioritize lists and kind of rank them and also be able to restate or maybe add something that didn't end up showing through in the first round.

And then the final stage was interesting to me, which is we gave everybody who was replying or being asked to reply 100 units of resources, which they could define however they wanted, and they needed to allocate those among the priorities. They could put 50 on one thing and 50 on another, and they're done. Or they could put 2 on a lot or whatever. So, it helped us to figure out—all of the things that were emerging, so many issues, were really important issues probably to all of Kansas and certainly to certain interests as well. But this allowed us to think, "Where are the greatest priorities?" both in terms of what we think has happened to health in Kansas—the project was called "What's Happened to Health in Kansas?" but also what could be done.

BSP: Can you give us an insight? What were the things?

KB: The highest—there's a full report that has a whole bunch of them. They're really interesting and good stories as much as anything. But I think the very highest rated was the impact of rural hospital closures and other access to care in rural communities. So, very timely now when we're recording it in May of 2026 when there's the Rural Health Transformation Program going on. So, that was one.

I know we'll talk about Medicaid expansion or coverage overall. Medicaid expansion was another of the highest priorities. Access to behavioral health services was also in that top tier. I know you're talked to other people, including Representative Landwehr, about some of the things that Kansas has done to really increase and improve access to behavioral health in Kansas. And then the last was really investment in the public health infrastructure.

So, those were the key things. Some of those things, you might think, "Those are not so surprising." But then there were stories underneath them as well. Workforce kind of shines through in so many of these, really in most of those priority issues, but it also stood out on its own. And there were other overall issues about sort of the culture of health and what do we think of it, what do we value as health in Kansas that also emerged as key themes.

BSP: Well, hopefully, I'm sure one of the goals of the project was to put this analysis out there for policymakers, community leaders to identify some of the areas where there are challenges and opportunities to try to make progress.

KB: Right.

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BSP: That's great.

KB: One of the key themes that came out of that, too, was it's probably not any one—just as there's no one thing that happened at one point in time that changed Kansas's health trajectory, its ranking trajectory, there's not even among those really high priorities, there's not one thing that alone is going to turn around that trajectory. So, it really argued for needing a playbook and a shared set of priorities for Kansans about how we improve health in Kansas. And the rankings help us because it will measure how we're doing, but if we're working on that same playbook together and improving health, no matter where the rankings end up, we're going to be better off as Kansans.

BSP: I'm going to use that as a segue to talk about some of the roles that you've played in leadership in the state to develop that playbook, that agenda, so to speak. It doesn't start anywhere more centrally than the governor's office. We left off when you were talking about your role at KU Hospital. Then you began to make a transition into state government. Tell me a little bit about that through working in the governor's office, for the governor on their development of their health policy.

KB: For a minute, I thought you promoted me to actually having been governor there for a second. When I was working at KU Health System, one of the things I got to do was participate in the Kansas Health Foundation Leaders program, the Leadership Fellows program that the Kansas Leadership Center ran. There, in 2009 and 2010, I met Dr. Bob Moser, who was at that time—I think he had just gone from being the family physician longtime and county health officer and a lot of other things in Greeley County in Tribune but was working with the University of Kansas Medical Center.

BSP: Right.

KB: When Governor Brownback was elected, he appointed Bob Moser as the secretary of the Kansas Department of Health and Environment. Dr. Bob, as we call him—you're also a Dr. Bob—I've worked for two Dr. Bobs—had reached out to me to see if I would be interested in working for him as an assistant secretary on the policy side of things in KDHE overall, but particularly because of my work—I didn't mention a lot of work that I had done at KU Health System was really in Medicaid. Some of those programs we talked about were heavily Medicaid like DSH, but there are other ways that I worked very directly with Medicaid. I was really interested in what they were thinking about at the time, how we could reimagine and think differently about the Medicaid program in Kansas. So, that's what took me to state government.

BSP: And you're right. You didn't work in the governor's office. I knew you and your role when you came over, but you certainly were one of the key people in the governor's realm, along with the lieutenant governor who was a physician at the time.

KB: Yes.

BSP: And you and Dr. Moser, Mark Dugan and others were really involved in setting the policy agenda for the administration.

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KB: And Andy Allison, another former KHI person as well. When I first started, that first year, I was working in the office of the Secretary. So, I wasn't in—at that time, the Medicaid program was part of the Kansas Health Policy Authority. There was legislation in that year, in 2011, I guess that makes it, to bring the Medicaid program back into a state agency but instead of—where it had been pre-Health Policy Authority in SRS [Social and Rehabilitation Services], it was going to be in KDHE. So, we worked really closely with the folks in the Health Policy Authority—Andy, and Scott Brunner at the time was the Medicaid director—on both that transition, that upcoming transition, and then also thinking about what Medicaid would look like moving forward in Kansas.

So, that first year was largely, we worked broadly on a lot of health policy issues in KDHE and environmental issues with a lot of focus on Medicaid. And then when Andy had the opportunity to go to Arkansas to do some really interesting and creative stuff in Arkansas, working with their Medicaid program, I had the opportunity to work at the division of health care finance, which by then had become sort of that's where the Health Policy Authority infrastructure had moved to.

So, a great opportunity to work there and learn a lot, bring some of my background experience, but also learn from a year of listening sessions and public meetings around the state about how could we change the Medicaid program. Then it led to the creation of KanCare, which is at the time one of the most comprehensive integrated managed care programs. So, Medicaid programs can have direct provision or payments by state Medicaid agencies to the providers, or they can do something called managed care, MCOs. Right now, they've been around long enough, so people probably think that is what Medicaid is, but managed care had been part of Medicaid and the children's health insurance program for many years in Kansas.

BSP: HealthWave.

KB: Right, through HealthWave, but it had not been part of services that were provided for people with disabilities and behavioral health services, although the behavioral health services also had a sort of quasi-managed care model, too, at the time, but a different model. So, that transition to a more comprehensive integrated managed care was a big transition for Kansas and a big part of what I did the first part of my years in KDHE, all my time at KDHE, really.

BSP: Part of your background, listening to constituents and people involved in the issues, I know you heard a lot about that proposed transition to managed care, encompassing disability services and those sorts of things. Tell me what some of the issues were that were being talked about at the time.

KB: Yes, big concerns, some of them as technical, but really practical and important, as making sure that providers who had only ever had to bill the state Medicaid agency who—the services they provide are not covered by other—or at least at the time certainly weren't covered by other insurance, a lot of the home and community-based services, for example, and what would it be like for them to be billing these big national companies that even though they had a Kansas face, they would now have three – one, two, or three – different ways to have to bill.

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So, trying to set up a system to transition that so that the providers who are providing the care that allow people to stay in their homes and their communities as long as they want to, it was important to get them paid not just from a like "Oh, we're taking care of providers," but that's also really taking care of the people that are receiving those services.

So, that was a big transition issue, one that we really focused on. And then I think a broader issue was sometimes the concern around-- would managed care organizations who had a lot of experience working with health care services really understand how to provide those other services that Medicaid provided and value them. There was concern about medicalization of some of the long-term disabilities and some of the supports for people with long-term disabilities.

BSP: The supports that help people stay in community settings.

KB: Yes.

BSP: They weren't medical care.

KB: Right.

BSP: They were services to support their everyday activities.

KB: So, it was important in the selection of the managed care organizations in the beginning that they had some experience working in states where they had worked with other services other than your "typical" medical services. But it was still one of the more comprehensive versions of integrated managed care. All the behavioral health services and those long-term services and supports in with the same managed care organizations that were doing health care was both a concern and a challenge, but also the opportunity.

The opportunity there was hopefully to have really person-centered care that is focused around the individual and their needs. The extent to which that's successful—we set up a lot of measurements, and my time at KHI, we've been trying to help measure and figure out about the success of that and some of the challenges of that. I think we did in the implementation a lot of those technical things, we were able to work through very effectively, but it was still a big culture change for providers and for the payers.

BSP: So, you were working with the governor's team and the Division of Health Care Finance, when a lot of this was developed and implemented. Unlike a lot of situations, you didn't then walk away and do something else. You then eventually became the secretary of the Cabinet-level agency that actually administered a lot of the programs that you're talking about.

KB: Yes. The Kansas Department for Aging and Disability Services, which was a combination of what had been the Kansas Department on Aging and the disability and behavioral health services that had previously been in what was then SRS that now is the Department for Children and Families, that was an agency that had also come in around the same time when KDHE had absorbed the work of the Health Policy Authority.

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If you remember, pre-Health Policy Authority, most of Medicaid was all in SRS, Social and Rehabilitation Services, and then mostly was in the Health Policy Authority, although the behavioral health services and the long-term services and supports and aging were still sort of distributed within SRS and the Department on Aging.

So, KDADS was the agency that had and still has programmatic authority for not just the Medicaid services for older adults and people with disabilities in behavioral health but definitely including those. I had the opportunity to work as the Secretary at that agency, and we didn't work only on Medicaid. It's a lot more than that, including the state hospitals as well. But I think it was really consistent with what I was interested in, what had really come to motivate a lot of my work, which is, growing up in western Kansas, this was also related to when I was in the KLC [Kansas Leadership Center] program with the KHF [Kansas Health Foundation] fellows, you're supposed to come up with your personal mission statement, and that was an interesting challenge. I had looked back on all of those things I had done up to then. That was when I was still at KU Health System. I thought for me, it [mission statement] is where people choose to live shouldn't determine their outcomes. And we know that based upon a lot of the research that where people are born or where they live right now absolutely—there's a high correlation to some of that—not just health outcomes but other outcomes as well.

And an agency like KDADS, the mission is to help people stay where they want to live, live where they want to live, live in their homes, be able to access services in their communities as long as they want to, as long as they choose, by providing services that aren't typically going to be provided just through health insurance, the typical health insurance. I really valued KDADS and still value the work that they do now as well. I learned a lot. It was a different—I had worked with a lot of the stakeholders, with KDADS stakeholders when we were going through the KanCare implementation as well. So, I knew a lot of folks, but I got to know their programs and the work that they do even more closely at KDADS. There's incredible dedication, not just on the state agency staff, but the folks in those sectors who work in providing those services. So, it was an honor to get to work with them and get to know them and still be able to get to work with them now in my current role.

BSP: And caring for a group of very vulnerable citizens of our state that rely on these services and supports to have a fulfilling life.

KB: Absolutely, but also acknowledging one of the things that really resonated with me then and still does, is that it's also empowering and recognizing the power that those folks have. Not only are there some things that can be seen as vulnerabilities are also part of people's identities and their strengths. We're part of something called Age-Friendly Kansas now at KHI, for example, working with KDADS and KDHE. So, reframing how we think about age or even disability, or thinking of health more broadly than just like "We've got physical health and we've got behavioral health, and they're in separate"—but really thinking about health as around the whole person. That's really what KDADS's work is all about.

BSP: So, we talked a lot about KanCare and how it really brought the concept of managed care to Medicaid in Kansas. Another big policy issue around Medicaid is Medicaid expansion. Tell

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me if that was part of the conversation at the time. It certainly has become a part of the conversation since then, and how the Medicaid expansion question played out over your time and your various roles in state government.

KB: Absolutely. We talked about that a little bit when talking about what leaders had identified, some of the Kansas health leaders, had identified as a key policy issue for health in Kansas. When we were working on KanCare and managed care, at that time it was assumed that there would be Medicaid expansion because the Supreme Court hadn't ruled yet, or it was assumed that the entire ACA might go away, that the Supreme Court might strike it down. So it was like, there was either going to be definitely expansion or there wouldn't be an Affordable Care Act. And then instead as you know what happened was most of the Affordable Care Act in fact stood, but states had the option to either expand Medicaid or not.

So, it definitely changed some of the discussion. We were building a system that could work either way, with an expansion population or without an expanded Medicaid population. For those folks who don't know, Medicaid expansion is for adults regardless of whether they have children who have a household income under 138 percent of the poverty level. In Kansas, for adults who if you don't have a disability or are not an older adult or not otherwise eligible, the only way you're eligible for Medicaid is if you have children, so you're a caregiver, either a parent or a caretaker of children who are eligible, and your income is under 38 percent of the poverty level. So, there's a big difference. That was a discussion at the time—

BSP: Just to give some context, 38 percent of the poverty level in Kansas for a family of four is roughly $12,000 or something like that.

KB: It's very low.

BSP: We're talking about people who have some income, are working, but not making much money.

KB: Right. I remember one of the other times I met you, it was not the first time. We definitely crossed paths over that. I came over to a convening that the Kansas Health Institute had with Scott Brunner who was on KHI staff at the time, a gentleman I think from the Cato Institute.

BSP: Yes.

KB: And me, representing the state, talking about the three very different estimates of what Medicaid expansion would either cost and the number of people who would enroll in Medicaid if expanded. A lot of the focus I had early on was really trying to figure out, "What would this look like if we were to expand Medicaid? How many enrollees would we expect?" I remember the KHI numbers and KDHE numbers. The tally was actually pretty close.

BSP: The Cato numbers were like an order of magnitude—

KB: It was quite a bit higher. A lot of the discussion in the early years, it seemed like—and I think some of this persists to this day—was a matter of what we would think it would cost the

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state and what would the other options be if we could do this in a different way, in a way that would cost the state less, or some folks had opposition based upon either opposition to the Affordable Care Act overall or philosophically to the idea that a direct government program should be providing those services.

The focus that I had working at KDHE really was trying to figure out what the cost and the enrollment numbers would look like. That was more of the early focus and discussion, I think. It has evolved. You know this in the sense that in my time at KHI, we do use similar methodology to what Scott and the team had used at the time at KHI to estimate both the cost but also the offsetting savings from expanding Medicaid would look like. But I think there's been less and less—my impression anyway is there's been less and less focus on the discussion of cost or savings or anything in that mode and really more about sort of the role of government. I think that has become at least in the current legislature, that's sort of more the perspective. That can change. We had at one point the legislature did opt to pass Medicaid expansion legislation that was then vetoed. They didn't have the votes to override the veto. So, that could change in future years.

Some of the changes in H.R.1, the federal legislation OBBBA [One Big Beautiful Bill Act], removed some of the incentives for expansion, some of the extra funds that were going to be available that had been added for a couple of years, but the underlying funding structure is still in place. It's still an open policy discussion, but one that I think has evolved from being about what we think it's going to cost and how many people are going to be enrolled to something maybe more—I don't want to say more philosophical, because I think it always had that element, and political, it always had that element. I think there's more of that element now than it ever has.

BSP: A lot of times, the policy arguments are not really about the policy issue. They're about these philosophical sort of higher-level issues. I think it was that way with Medicaid expansion early on. "What are the numbers? Let's figure out exactly a number." I think maybe it's a healthy thing that the conversation has evolved more to those underlying values and assumptions about the role of government.

KB: I think the other thing that has evolved now is that there's discussion about other ways to also improve access to care and quality of care and affordability of care. That's not an either/or. You can do that and also expand Medicaid or have that conversation on expanding Medicaid, but I think there's even more voices talking about other ways we can also improve access to care.

BSP: Supporting the safety net, providers.

KB: Also addressing cost, the out-of-pocket cost. Coverage is certainly still a primary discussion point, but there's more and more about affordability, even for folks who do have insurance coverage.

BSP: Okay, good.

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BSP: I think before we started this conversation, you were commenting, gosh, you don't know what you have to say about this particular set of issues. When I think of what we've covered, you've touched on just about every aspect of the health system writ large, not just the hospital health care system, but all these other kinds of roles and programs that you've played a really important role in.

KB: I've learned so much along the way, though. At one point, you said maybe we'd talk about "What made you go from this job to the next job?" Serendipity, for the most part. It's really interesting to me, I think just the opportunity. That first ride in the car with Senator Kassebaum, not the first ride, but when I was interviewing her. I think that opened doors that I wouldn't—who knows what I would be doing? Hopefully, I'd still be driven by that same mission for people to be able to choose where they want to live and have that not determine their outcomes. It probably would not have followed down the path of health and health policy the same way it has. I think just taking those opportunities and having humility. I have to have humility, because everywhere I've gone to work with somebody else, they always know more than I do when I get there. So, learning from them and being able to take that to the next step.

I've enjoyed the time, and I hope it's not done. I hope we'll be around, seeing where we are with the next phase of – the Rural Health Transformation Program is really exciting. It comes at a challenging time, too. It's an opportunity to invest in rural health, but it's at a time when there's also challenges for reimbursement. The same legislation that created the Rural Health Transformation Program also has impacts on Medicaid funding for providers as well and for enrollees.

BSP: Health policy is a very high job security role because we've been dealing with these issues for a long time. We have a lot of work to do still.

KB: There is a lot of work to do.

BSP: I think we could do a whole separate interview on what you've done since you've left state government, but I think we'd better leave it there for today.

KB: That sounds good.

BSP: Thank you so much.

KB: I'll give you the short version of that. I got to work with this guy at the Kansas Health Institute and learn a lot. So, I appreciate that, both the opportunity to work with you and to talk today.

BSP: This has been awesome. Thanks, Kari.

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