Approved: February 8, 2012

MINUTES OF THE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman Vicki Schmidt at 1:30 p.m. on January 17, 2012 in Room 546-S of the Capitol.

All members were present.

Committee staff present:
Nobuko Folmsbee, Office of the Revisor of Statutes
Renae Jefferies, Office of the Revisor of Statutes
Iraida Orr, Legislative Research Department
Melissa Calderwood, Legislative Research Department
Carolyn Long, Committee Assistant

Conferees appearing before the Committee:
Representative Bob Bethell
Kevin Miller, CEO, Hutchinson Regional Medical System
Jerry Slaughter, Kansas Medical Society
Tom Bell, Kansas Hospital Association
Tom Laing, Executive Director, InterHab

Others attending:
See attached list.

The Chair opened the meeting by recognizing Senator Brungardt. Senator Brungardt wanted the committee to welcome his intern Teng Ge who is attending Washburn University.

The Chair polled attendees to ascertain if any were from either the Department of Aging, KDHE or SRS. Two individuals were from KDHE and indicated they would be reporting back to the other agencies.

The Chair recognized Representative Bob Bethell. Rep. Bethell introduced Mr. Kevin J. Miller, President/CEO, Hutchinson Regional Healthcare System and Hutchinson Regional Medical Center (Attachment #1). Mr. Miller previously served at the Cleveland Clinic as President/CEO of Astabula County Medical center and ACMC Healthcare System near Cleveland, Ohio. During his tenure he was actively engaged in representing his organization to the Ohio legislature and the state agency responsible for Medicaid services after Ohio implemented a Medicaid MCO program. He stated that he understood and supported the need for a Medicaid managed care

program in Kansas but cautioned that he did not want to see them make the mistakes made by Ohio with the majority of those specifically centered around issues of access to care for the population in a timely and ethical manner. Insurers were not required to create any drug formularies. Instead, physicians and their staffs were required to call the insurance company to obtain prior authorization for any and all prescriptions, home medical equipment, inpatient and outpatient hospital services, etc. As a result, the patients did not receive what they needed. Many physicians became frustrated and limited or eliminated their Medicaid practice. After several years, insurers finally developed drug formularies, but inadequate access to care remained an issue.

Jerry Slaughter, Executive Director for the Kansas Medical Society stated that while health care is a team effort, physicians represent the backbone of our health care system, and for any systemic reform of Medicaid to be successful, physicians must be active partners in the process. They acknowledge the skepticism about expanding the reach of Managed Care Organizations to Medicaid populations such as the aged and developmentally disabled, populations that have thus far been outside the traditional managed care systems. It is hard work, taking accountability for outcomes, paying attention to detail and making sure that the right care and services are provided at the right time in the right setting. However, managed care does give the state the ability to predict, and fix, its costs in the program with some certainty. Companies selected need to be able to improve communication and coordination among care providers, improve care transitions, reduce duplication of services, and eliminate fragmentation (and the care "silos" that are so prevalent today), then not only will outcomes improve but it would begin to slow the growth in spending. The Kansas Medical Society is committed to working with the legislature and the administration to help ensure that we have a patient-centered, high quality Medicaid program that is fiscally sound and sustainable (Attachment #2).

The Chair recognized Tom Bell, President and CEO of the Kansas Hospital Association (KHA). Over the years, Kansas hospitals have worked in partnership with the state to insure that our most vulnerable citizens have access to quality health care. They recognize that the current trajectory for Medicaid expenditures are not reasonably feasible and that initiatives must be developed that will improve outcomes and reduce costs, especially those that result from excessive redundant rules and regulations that have little correlation to quality care. The KHA formed a task force to identify a set of criteria that they felt should be considered under a reformed Medicaid program. The task force identified five specific domains that impact hospitals: access to care; delivery system reform; care management; provider reimbursement; and issues related to the hospital provider assessment program.

The minutes of the Public Health and Welfare Committee at 1:30 p.m. on January 17, 2012 in Room 546-S of the Capitol.

Hospitals are significant stakeholders and providers of care for the State's Medicaid enrollees. As such they recognize the tremendous task in reforming and redesigning the program (Attachment #3).

Representing InterHab, Tom Laing, Executive Director, addressed the Administration's proposed global changes to the State Medicaid-based programs and services and particularly the community-based supports that thousands of Kansans with intellectual and developmental disabilities depend upon each and every day. They do not oppose this approach; however, they do oppose the incorporation of long-term service funding for persons with intellectual/developmental disabilities into the KanCare contracts. He urged the Committee to take steps needed to assure that the HCBS DD Waiver (and ancillary support funding for targeted case management, employment services, etc.) for persons with I/DD not be included in the KanCare program. The case for removing I/DD long-term care services from KanCare include the following: KanCare is a medical program, I/DD long-term care is not; KanCare will complicate the current model of long-term care, mandating new layers of administration and contracting; and, administrative complexities will translate into high administrative costs. If the decision of the Administration and the Legislature is to go forward with KanCare as is, they recommend that all interest earned on KanCare funds should be recouped by the State and re-invested in program waiting lists and rate adjustments; all legislative oversight committees should request staturorily-established subpoena powers for themselves; auto-assignment should not occur for persons whose primary benefits are their DD services; and proponents from the Administration and from the Attorney General's Office of Medicaid Fraud and Abuse should provide detailed staffing schemes and responsibility roles for oversight (Attachment #4).

The Committee's attention was directed to written testimony submitted by Cathy Harding, Executive Director, Kansas Association for the Medically Underserved (Attachment #5).

The next meeting of the Committee is Wednesday, January 18, 2012 in Room 546-S of the Statehouse.

The meeting adjourned at 2:30 p.m.