Approved: February 16, 2007
Date

MINUTES OF THE SENATE HEALTH CARE STRATEGIES COMMITTEE

The meeting was called to order by Chairman Susan Wagle at 1:30 P.M. on January 22, 2007 in Room 231-N of the Capitol.

Committee members absent: Senator Jim Barnett - excused

Committee staff present: Ms. Terri Weber, Kansas Legislative Research Department
Ms. Nobuko Folmsbee, Revisor of Statutes Office
Mr. Jim Wilcox, Revisor of Statutes Office
Ms. Margaret Cianciarulo, Committee Secretary

Conferees appearing before the committee: Mr, Fred Schuster, Regional Director, US Department of Health and Human Services
Mr. Robert Epps, Health Care Specialist, Centers for Medicare & Medicaid Services

Others in attendance: Please see attached Guest List

Recognitions

Upon calling the meeting to order, Chairperson Wagle introduced the newest member of the Committee Staff, Ms. Nobuko Folmsbee, who will be the primary Revisor as she is for the Senate Public Health & Welfare Committee . Mr. Jim Wilson will still be available to help her out. The Chair also recognized returning staff members. She then went on to state that she is waiting to see what recommendations the Senate Public Health and Welfare Task Force Committee will make regarding a portability initiative, for the Senate Health Care Strategies Committee to consider.

Overview

The Chair then introduced Mr. Fred Schuster, Regional Director, US Department of Health and Human Services, who offered a brief overview of Value Based Health Care (VDHC) and 4 cornerstones:

1. Interoperable Health IT system or Electronic Health Records,
2. Quality Measures,
3. Price Standards, and
4. Properly Placed Incentives

He also offered a brochure stating that at the bottom of page 13 is the website to see what others are saying and what businesses have signed the pledge. A copy of his testimony is (Attachment 1) attached hereto and incorporated into the Minutes by reference. A copy of the brochure is filed in Senator Wagle's office.

Mr. Schuster then introduced Mr. Robert Epps, Health Care Specialist, Centers for Medicare and Medicaid Services (CMMS), who stated that they used to be known as the Health Care Financing Administration. He stated their Center administers the Medicare and Medicaid and the relatively new children's health insurance and until recently, have been a passive bill payer. However, with the cost increases, they are trying change and become a prudent value driven purchaser of health care services. (He cited that 16.3% of our gross domestic products is spent on health care, projecting 20% spending by 2015, and the 2 closest countries are Sweden and Germany, both barely over 10%.)

As an overview of what the Centers for Medicare and Medicaid are doing that relates to the new transparency initiatives, Mr. Epps stated, over the last 4-5 years they have been involved in a number of demonstration projects, ex. Long term care facilities and hospitals, trying out methods of making quality transparent with relative success at this point. They now have primitive information on the website named " Cms.hhs.gov "(Ex. Of what it is offering: Information that indicates the Medicaid payments for different types of service; a hospital comparison (reports on a limited number of quality indicators for approximately 4,000 hospitals across the country) and preventive services (Ex. a "Welcome To Medicare"

screening that is available to beneficiaries as they enter the program, along with cardiac, diabetes, mammogram screens as a result of the MMA 2003 legislation that passed that gave them the prescription drug benefit.) No written testimony was offered.

The Chairperson then thanked the conferees and asked the Committee for questions or comments, Senators Schmidt, Palmer, and Wagle asked a range of questions including:

a) regarding transparencies -where are the guidelines for guardians/recipients being put on a list and are these names published, and could a state, if they chose, put the names of those Healthwave beneficiaries on a web page;

b) concerns regarding privacy in general;

c) regarding the hospital comparison- there can be a lot of differences in the state of a patient that is admitted to the hospital with other issues that come into play & this chart does not seem to address those (Ex. , KU Med center probably takes patient that are much sicker than a hospital in Dodge City and therefor would expect their patient satisfaction might be less and their outcomes would be markedly different because of the state of the patient on the way in.) is there any way to ascertain that in your website;

d) regarding Medicare Part D, still some kinks (have been working with some constituents for over a year) do you see any help for this;

e) regarding the autism act, millions of dollars have been allocated for that, do you know when the funding will be available; was it an absolute mandate that if you do business with the federal government you have to abide by these principles and publish your cost;

f) requesting clarification - you have this information (sign up sheets)from about 40% of your companies and is it just for businesses; (reply - their goal is at some point, where there is enough people being covered nationally, that insurance companies and providers will just do it for everybody, with the tipping point is maybe 60-70% coverage point);

On the same subject:

1) are you asking people to request their providers to comply;

2) have you heard of any initiatives from Kansas that are asking for compliance; and,

3) do we have an Executive Order and are there any states who have participated?

Adjournment

As there was no further questions or discussion, Chairperson Wagle asked if there were any bill introductions. As there were none, the meeting was adjourned. The time was 2:25 p.m.

The next meeting is scheduled for January 30, 2007.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: Tuesday, January 22, 07

NAME	REPRESENTING
MARK P MARTZ	VIA CHRISTI REGIONAL MED. CTR
Mary Ellen Conlee	Via Christi Health System
Suzanne Wikle	Kansas Action for Children
Abbie Hodgson	SRS
Cara M. Greve	KAMU
Sheena Smith	KS Chamber
Kate Gilbert	Kearney & Associates
Chad Austin	KS Hosp Assoc.
Tish Hollingsworth	Ks Hospital Assoc
Sheli Sweeney	Assoc. of Community mental Health Ctrs
Derek Hein	Hein Law Firm
Kerri Spielman	KAIA
Luke Thompson	KHPA
Carolyn Middendorf	Ks St Ns Assn
David Klepper	KC Star
Joshua Lewis	Sen. D. Schmidt
Robert Epps	DHHS/CMS
Michelle Peterson	Capitol Strategies
Erika Hart	Fellprico consulting

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January 22, 2007

I wanted to provide a brief overview of VDHC and then Robert Epps and I will try to answer your questions.

HC rising 3x faster than wages
GM reports spending more on HC/car than steel in the car
We pay twice as much for health care as our global competitors
1951, HC occupied 4% of total economy. Doubled to 8% by 1977 and doubled again to 16% in 2006

I want to first acknowledge something that I think you all know, the main thing driving health care costs up is our personal habits. We do not take very good care of ourselves ie diet and exercise.

There is another contributing factor and that is the way our HC system [sector] is organized ie there is nothing that connects our rapidly growing health care into a system. Such as what we have e.g. in our banking system {airlines, telephone and the internet are other examples}. Each has competition for our business, but each entrant has adopted.

I remember when growing up when I made a deposit at a bank, prior to 1975, I had to have a human teller, who would either type my deposit or hand me a slip of paper. Now we use ATMs almost anywhere in the world. Our HC should have a like system.

Attempts to organize HC into a system have been going on for over 20 years, but have not been totally successful, in part because the federal government has not been participating. That started to change when in August 2006,

Senate Health Care Strategies Committee
Date: January 22, 2007
attachment N

President Bush signed an executive order saying that if you want to do business with the federal government, e.g. bidding to provide HC coverage to employees, you must agree to support the four cornerstones that will help turn our HC sector into a system.

4 CORNERSTONES

1. Interoperable Health IT system or Electronic Health Records
2. Quality Measures
3. Prices Standards
4. Properly Placed Incentives

The federal government, Medicare, Medicaid, DoD, VA and OPM pays for nearly 40% of the health care in America, along with other employers, unions, state governments and other governments, these four cornerstones will move us to value driven health care.

Briefly, Interoperable simple means that hospital computers in Topeka can talk to hospital computers in Lawerence, Wichita, Ulysess, Garden City, Jefferson City, Denver, Lincoln, Des Moines and everywhere around the US. Why is this important? Your records can appear in another hospital with a click helping the attending physicians make critical health care decision about you if you are unable to communicate or can't recall your prescriptions or medical history. You also will not have to repeat filling out forms in the doctors office or carry your x-rays. Finally, it should reduce medical errors when the physician sends your prescription to the pharmacist by e-mail instead of hand writing.

The second Cornerstone deals with quality measure. It is considered impolite to ask a Doctor about their quality. Like any other service, some providers are better than others. Quality of care is of critical interest to patients, their health and even their lives can be at stake. Patients need to know. Doctors, like you are very competitive people and only want the best for their patients. Doctors would like to know how they are doing and how they compare with their peers. Measuring Quality is complex, but we do it in other areas, e.g. hospitals and nursing home. Give Examples

For this, organizations of insurers and providers themselves are working on these standards of quality measurements.

The third cornerstone deals with price standards. Generally speaking , price isn't as big of consideration in health care as it ought to be and that is a big problem. People with Health Insurance often don't care about price. And it would not do a lot of good to ask because the provider probably does not know. After care is provided, people start to receive a lot of bills from the doctor performing surgery, hospitals and other folks involved. The billing system is incomprehensible containing medical codes, co-pays etc.

Ways are being developed in devising ways to group medical charges in more understandable ways known episodes of care. When cost is understood, it allows consumers to compare cost and quality to determine value. It is not only good for patients such information will also assist doctors and hospitals. Without consciousness of the entire cost of a medical episode, practitioners lose site of value.

The fourth and final is Proper Incentives. With information on quality and price availability, consumers, doctors and hospitals can be rewarded for making decisions that increase quality and lower costs.

The four cornerstones are not an easy thing to do even with the federal government involvement. More must be done to make this happen. Currently we are asking businesses and other purchasers of health care including state governments to ask the same of their insurance providers. To ask them to agree to the four cornerstones I described. On pages 7 and 8 is a prototype of what the information could look like.

There is a lot more I could discuss, however in your brochure, at the bottom of page 13 is the website to see what others are saying, what businesses have signed the pledge, and I believe there are over 175 purchasers ie business and state governments, that have signed. I would ask Kansas to do the same.

I would ask if Robert has anything to add and if not , we will try to answer your questions.