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 18, 2012, in Room 548-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, Kansas Legislative Research Department
Melissa Calderwood, Kansas Legislative Research Department
Carolyn Long, Committee Assistant

Conferees appearing before the Committee:
Mike Hammond, Ex. Director, Assoc. of Community Mental Health Centers of Kansas
Doug Funk, President, Kansas Pharmacists Association
Bob Williams, KS Association of Osteopathic Medicine
Mike Oxford, Ex. Director, Topeka Independent Living Resource Center
Dr. Ira Stamm, Ph.D.

Others attending:
See attached list

The Chair opened the meeting by welcoming members of the Kansas Academy of Family Physicians in recognition of Family Medicine Advocacy Day.

Mike Hammond, Executive Director, Association of Community Mental Health Centers of Kansas was introduced. The Association represents the 27 licensed Community Mental Health Centers (CMHCs) in Kansas that provide home and community-based, as well as outpatient mental services, in all 105 counties in Kansas. As part of licensing regulations, CMHCs are required to provide services to all Kansans needing them, regardless of their ability to pay. This makes the community mental health system the "safety net" for Kansans with mental health. He noted that the administration has proposed an ambitious approach through improved care coordination and reduced fragmentation across programs to improve overall health outcomes for medical beneficiaries and to slow the growth of Medicaid expenditures all while preserving Medicaid rate, eligibility, and benefit. The Association agrees that the path the state is on today is not sustainable.

In 2007 the public mental health system transitioned to managed care for Medicaid reimbursed services. It was implemented as a carve-out where benefits are managed separately and independently from physical health and substance abuse. The Administration is choosing to

integrate all populations in their Medicaid reform approach. The Association does not disagree that integration of care can also be achieved in an integrated plan or that the sustainability of the current path of Medicaid in Kansas is concerning, but that if we as a State do not address sustainability, the Association fears cuts to their system might continue.

The devil is in the detail and that detail will be in the contract between the State and each MCO, as well as in how each contract is implemented. The administrative costs will most definitely increase having to navigate the necessary system requirements for each of the three MCOs. The system has been financed on fee-for-service basis historically. The reimbursement model to be used by each MCO is unknown to the CMHC. Any interest earned on KanCare funds paid to the MCOs should be recouped by the State and reinvested in programs. Ensuring there is adequate and effective oversight in the Executive Branch as well as the Legislative Branch will be critical. In the end, access to care when it is needed and at the right amount is paramount and they remain strong in their advocacy to ensure that continues (Attachment #1).

Doug Funk, representing the Kansas Pharmacists Association, says his organization recognizes the difficulty the administration and legislators have in balancing the well-being of Kansas' Medicaid population with the fiscal realities all of us are dealing with. Kansas currently has three configurations of managing Medicaid in Kansas. One is a fee for service Medicaid program administered by the state of Kansas. The other two are managed-care organizations; Children's Mercy which is a healthcare network based in the Kansas City area and Unicare, a multiple-state managed-care organization. His analysis shows that the two managed-care companies that currently contract with Kansas pay on average between 19% and 52% below what fee-for-service Medicaid pays toward the gross margin. He feels the reason is profit for the MCOs. He and his colleagues have established personal relationships with patients that give them a better chance of influencing them directly if given the opportunity but given the time they spend on payment procedures precludes that from happening. There are many reasons he is opposed to managed-care organizations running the Medicaid program; noteably that MCOs are slow when it comes to updating drug prices and usually only when in their favor and they have a mail order pharmacy component to them (Attachment #2).

Bob Williams, Executive Director of the Kansas Association of Osteopathic Medicine (KAOM), said that physicians have the same concerns with KanCare/Medicaid as they have with any third party program. Their concerns include: is there adequate coverage of procedures so physicians can prescribe an effective care plan for their patients; is there adequate coverage of preventive health services; is the claim filing process easy with fast turnaround time and simplified claim

filing procedures; will reimbursement be adequate to maintain services; and, how intrusive will the program be.

While federal and state governments are "reforming" health care, there are a number of innovative programs funded by private sources which hold a great deal of promise in terms of providing optimum health care and cost savings. An initial coalition comprised of the Kansas Medical Society (KMS), the Kansas chapter of American Academy of Pediatrics (KCAAP), the Kansas Chapter of the American College of Physicians (KACP), and KAAOM put together a grant proposal to select eight physician led practices to serve as pilot practices in the Kansas Patient Centered Medical Home Initiative. Their goals were: all people have better access to doctors; each person knows a primary care physician; access is available regardless of income or insurance; visits to emergency rooms and complications caused by not having a doctor are reduced; and electronic medical records are used to improve quality, safety and efficiency of health care by improving communication about and with patients. A copy of their first six month Interim Grant Report was included with the testimony (Attachment #3). The Committee requested a copy of the next six month report as well.

Mike Oxford, Executive Director of the Topeka Independent Living Resource Center (TILRC), informed the committee that the Center is a civil and human rights organization. Their mission is to advocate for justice, equality and essential services for a fully integrated and accessible society for all people with disabilities. They have been providing cross-age, cross-disability advocacy and services for over 30 years to people with disabilities. The Agency is committed to assuring that people who require long term care services have access to information, services and supports that offer choices; choices that promote freedom, independent lifestyles and dignity, including the dignity of risk.

No other state has even attempted to convert their entire Medicaid program over to managed care so quickly. No other state has attempted the move into managed care without first engaging in limited impact modeling of the new managed care program. TILRC is of the opinion that the "Agency with Choice" model selected by the State and the rules developed to implement it do not comply with State Law (Attachment #4).

Kansas Advocates for Better Care was represented by Mitzi E. McFatrich, Executive Director. Ms. McFatrich said that older adults live in nursing homes for 2.9 years through the end of their lives. They give up nearly everything they have—privacy, daily freedoms, and most of their money—in exchange for care. Her organization recommends real outcomes that measure health improvements for older adults and Medicaid funding for adult dental health and geriatric mental health. The concerns of older adults are gaps in coverage, no coverage for adult oral health, no coverage for mental health, individual outcomes vs. Medicaid program outcomes, nursing homes and the quality of providers and quality care, and institutional vs. home based care (Attachment #5).

CONTINUATION SHEET

The minutes of the Public Health and Welfare Committee at 1:30 p.m. on January 18, 2012, in Room 548-S of the Capitol.

Dr. Ira Stamm, Ph.D. shared that he is a psychologist who has been taking care of patients for 45 years. While at Menninger, he was a part of the marketing and business side that were trying to decide whether to enroll in managed care networks. Over a four year period he traveled with colleagues to the headquarters of about 100 insurance companies across the nation. During that time he saw firsthand the dramatic transformation taking place in healthcare in America (Attachment #6).

Information requested from SRS during the January 12, 2012 meeting regarding the Problem Gambling and Other Addictions Fund (PGAF) for FY 2011, FY 2012 and FY2013 was distributed to the Committee (Attachment #7).

The meeting adjourned at 2:30 p.m.

The next meeting is scheduled for January 19, 2012.