MINUTES

JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT

November 20-21, 2008
Room 143-N—Statehouse

Members Present

Representative Melvin Neufeld, Chairperson (Nov. 20 only)
Senator Jim Barnett, Vice-Chairperson
Senator David Haley
Senator Laura Kelly
Senator Vicki Schmidt
Senator Susan Wagle
Representative Bob Bethell
Representative Jeff Colyer
Representative Bill Feuerborn (Nov. 20 only)
Representative Brenda Landwehr
Representative Louis Ruiz

Member Absent

Senator Roger Reitz

Staff Present

Terri Weber, Kansas Legislative Research Department
Cindy Lash, Kansas Legislative Research Department
Reed Holwegner, Kansas Legislative Research Department
Kelly Navinsky-Wenzl, Kansas Legislative Research Department
Renae Jefferies, Office of the Revisor of Statutes
Nobuko Folmsbee, Office of Revisor of Statutes
Ken Wilke, Office of Revisor of Statutes
Shirley Jepson, Committee Assistant

Conferees

Joe Tilghman, Chairman, Kansas Health Policy Authority (KHPA)
Dr. Marcia J. Nielsen, Executive Director, KHPA
Dr. Andy Allison, Deputy Director, KHPA
Dr. Barbara Langner, Policy Director, Kansas Health Policy Authority (KHPA)
Bruce Witt, Vice-President, Kansas Health Insurance Association (KHIA)

Linda J. Sheppard, Director, Accident & Health Division, Kansas Insurance Department
Hareesh Mavoori, Director, Data Policy & Evaluation, KHPA
John Miall, Jr. Consultant to the American Pharmacists Association
Ben Blumb, American Pharmacists Association Foundation (AphA Foundation)
Dr. Mary Redmon, representing the Medical Society of Johnson and Wyandotte Counties
Penny L. Vogelsang, Chief Operation Officer, Wichita Center for Graduate Medical Education (WCGME)
Jim Mitchell, Director, Heartland BioVentures and Investments, Kansas Bioscience Authority
Linda Steinke, State Director, UniCare Health Plan of Kansas
Bob Finuf, CEO, Children's Mercy Family Health Partners (CMFHP)
Cindy Peterson, Vice-President, Clinical Operations, Cenpatico Behavioral Health Systems
Carla Deckert, Project Manager, MAXIMUS

Other Attendees

See attached list.

Thursday, November 20
Morning Session

Approval of Minutes

Representative Bethell moved to approve the minutes of the August 14, 2008, meeting as written. The motion was seconded by Senator Schmidt. Motion carried on a voice vote.

Progress Update – KHPA

Joe Tilghman, Chairman, KHPA, presented an update on the accomplishments made during the past year by KHPA in focusing on improving the health of Kansans (Attachment 1). Highlights of these accomplishments include:

Medicaid/Health Wave

- Reformed Disproportionate Share Hospital (DSH) reimbursement which will provide at least $26.5 million in federal matching funds annually for treating indigent patients;
- Increased efficiencies by using standard medical identification cards;
- Expanded dental care to pregnant mothers and preventive and restorative dental care. Electronic billing for dental services has increased to 80 percent as more dentists are taking advantage of the online billing option;

- Increased enrollment in the Working Health Program which allows people with disabilities who are working, or interested in working, the opportunity to maintain Medicaid coverage while on the job;

- Increased administrative efficiencies through document imaging technology that manages documents and makes them more portable and accessible to users; and

- Complied with new state and federal provider identification requirements for the submission of all pharmacy claims.

State Employee Health Plan

- Increased the employer contribution rate for dependent coverage from 45 to 55 percent;

- Provided a broad range of wellness programs for state employees. Approximately 16,300 members took advantage of the personal health assessment and over 9,000 individuals participated in health screening events;

- Implemented the CareEntrust program, a Health Information Exchange pilot program; and

- Received recognition from the national Institute for Health and Productivity Management for innovative strategies in the 2009 State Employee Health Plan which were designed to control costs and promote healthy lifestyles.

Statewide Initiatives

- Completed plans to implement data analysis infrastructure by Fall 2009;

- Launched an online Health Consumer search tool in January 2008 to assist consumers by empowering them with resources to stay healthy;

- Began to operationalize the Medical Home Model by convening a stakeholder group that includes providers, consumers, and health plan and business representatives with the goal to create a medical home model for Kansas that includes incentives for payment reform;

- Implemented the E-Health Advisory Council to explore options to leverage the state's purchasing power to promote the use of health information technology and provide recommendations on policy issues related to health information technology; and

- Was selected, along with eight other states, to participate in the State Quality Improvement Institute designed to help states develop and implement substantive action plans to improve performance across targeted quality indicators.

The Committee requested a report from KHPA on the progress of the National Provider Identifiers (NPI), directed at transforming how claims are processed. The Committee also requested information on the number of people accessing the Online Health Consumer website, feedback

received, who uses the site, and what could be added to make the website more useful. With regard to the State Employee Health Plan, the Committee requested a report on changes made to the mental health portion of the state plan and how the federal Mental Health Parity Law will effect the Kansas plan.

2009 Health Reform and Recommendations

Dr. Marcia Nielsen, Executive Director, KHPA, provided testimony on health reform (Attachment 2) and the 2009 Health Reform Recommendations (Attachment 3). Dr. Nielsen noted that budget shortfalls within the state will have an impact on how KHPA proceeds with the 2009 Health Reform Recommendations. Dr. Nielsen also noted that KHPA had implemented budget reductions to comply with budget cuts as requested by the Division of Budget and that no supplemental funding was included in the agency budget requests, as discussed at the August Committee meeting.

The Committee requested detailed information on the FY 2009 and FY 2010 budget cuts.

Dr. Nielsen reported that the statewide number of uninsured has increased to 12.5 percent with adults, ages 19-34 making up 42 percent of the uninsured. Kansas is one of only 10 states with a rising rate of uninsured in 2007.

The Committee requested a demographic breakdown of the uninsured population in Kansas.

2009 Health Reform Recommendations include:

- Implement a statewide clean indoor air law to save lives and health care costs;
- Increase tobacco user fees to generate approximately $87.4 million in new revenue to expand health care coverage for low-income individuals, young adults and small businesses;
- Increase access to affordable health care and prevention for small business and young adults; and
- Continue the 2008 Health Reform Recommendations to:
    - Facilitate a statewide community health record information and exchange system to improve efficiency and promote cost savings;
    - Expand early detection cancer screenings;
    - Coordinate school health and workplace wellness for small businesses;
    - Improve tobacco cessation in Medicaid; and
    - Improve outcomes and promote cost effectiveness by investing in long-term health reform and Medicaid transformation goals.

Responding to a question from a Committee member, Dr. Nielsen noted that the penalty for participants in the State Employee Health Plan who do not refrain from smoking, is to pay the full insurance premium without the state discount for non-smokers or those participating in the smoking cessation program. At this time, there is no random smoking test of state employees; however,

employees are encouraged to participate in the smoking cessation program. Dr. Nielsen stated that all tobacco products are included in the tobacco tax increase. Medicaid participants are not included in the insurance premium discount at this time.

2008 Medicaid Transformation Plan and 2009 Medicaid Transformation Recommendations

Dr. Andy Allison, Deputy Director, KHPA, presented a summary of the 2008 Medicaid Transformation Plan and the 2009 Medicaid Transformation Recommendations (Attachment 4). Dr. Allison noted that Medicaid spending in FY 2009 is approximately $2.5 billion (All Funds, all agencies). It is anticipated that Medicaid will grow by 5.5 percent in FY 2009 due to a combination of growth and cost in the plan. Dr. Allison reported that remaining Medicaid challenges include:

- Steadily rising costs;
- Strained relationships with providers;
- Major gaps in coverage;
- Need to focus on prevention and wellness;
- Need to focus on quality of care;
- Need to focus on market impact; and
- Need to focus on data-driven management.

2009 Medicaid Transformation Recommendations include:

- Budget initiatives savings of $11.7 million over five years with pharmacy management, outreach initiatives and qualify data collection;
- Administration actions saving $16.6 million over five years; and
- Revenue dependent options with regard to coverage of parents living in poverty.

Responding to Committee members questions, Dr. Allison stated that the KHPA is proceeding with administrative initiatives as the budget allows at this time. The Committee expressed concern with the use of a phase-in system as applied to the purchase of an automated prior authorization (PA) system because funding was not fully appropriated by the 2008 Legislature. Dr. Nielsen noted that drug safety is an issue; and because the automated process was not funded, KHPA is looking for other ways to be cost effective. KHPA will create a panel of experts to manage mental health drugs and determine what drugs are put on the PA list. Dr. Nielsen indicated that this panel of experts is expected to be in place by the end of March 2009. She also noted that the PA system is very important to speed up the approval process and make the system much more cost effective.

The Committee requested that a list of potential members to the mental health panel who will determine acceptable mental health drugs, be made available to the Committee. It was noted that the Committee has no involvement in the selection of the panel.

Afternoon Session

Status of 2009 Legislative Studies

Dr. Barbara Langner, Policy Director, KHPA, presented testimony on the status of the 2009 legislative studies as directed by the Legislative Coordinating Council (LCC) (Attachment 5). The attachment provided detailed information including the study, the agency conducting the study and the current progress of the study.

Follow-up Information

Dr. Barbara Langner provided a follow-up response to questions posed by the Committee at the August 14, 2008, meeting (Attachment 6). Responding to a question from a Committee member, Dr. Langner stated that the average Medicaid rate is 83 percent compared to Medicare on all codes. Dr Langner noted that KHPA is planning a thorough review of reimbursement rates.

Study of 2008 Premium Assistance Legislation Proposed by KHPA

Dr. Marcia Nielsen provided an update on the Premium Assistance Study as requested by the LCC. Dr. Nielsen stated that considerable research was done before the issue was brought to the 2008 Legislature. Because no funding was appropriated by the 2008 Legislature, KHPA has not pursued any more research or analysis of the subject.

Dr. Nielsen requested direction from the Committee regarding further study on Premium Assistance. The Committee indicated that because of current budget constraints, the appropriate action would be to maintain the current program and not add any enhancements at this time.

Kansas Health Insurance Association Study of High Risk Pool

Bruce Witt, Vice-President, Kansas Health Insurance Association (KHIA), presented testimony pertaining to the study of the High Risk Pool (HRP) (Attachment 7). Mr. Witt stated that KHIA was created by the Kansas Legislature in 1992 to provide insurance for individuals with health conditions that make it difficult for them to obtain health coverage and who are not eligible for Medicare or Medicaid. Kansas is one of 35 states who have established HRPs. At the end of 2007, there were an estimated 201,000 enrollees across the U.S. with approximately 1,907 enrollees in the KHIA HRP program. Coverage requires proof of Kansas residency for the prior six months, ineligibility for Medicare or Medicaid, and involuntary termination of health insurance coverage for reasons other than nonpayment of premiums. Evidence must be provided that the applicant was rejected by two health insurance carriers because of health conditions, quoted a premium rate that exceeded the Plan rate, or was accepted for coverage subject to a permanent exclusion of a pre-existing disease or medical condition.

Mr. Witt reported that the recent loss ratio for KHIA was 185.3 percent, up from 167.2 percent in the prior 12-month period. Losses are expected to average about $1 million per month in 2009 with a loss of approximately $6,000 per patient. An expansion to the current program would require additional funding from new sources or greater reliance on current sources, such as premium revenues, assessments, and federal funding. Expansion of the program would also require new legislation.

Responding to a question, Mr. Witt indicated that the average premium for the uninsurable is approximately 130 percent over the standard premium rate.

KHPA Data Consortium Activities

Hareesh Mavoori, Director of Data Policy and Evaluation, KHPA, presented testimony on the Data Consortium (Attachment 8). Mr. Mavoori reported that the formation of the Data Consortium was chartered by the KHPA Board in April 2006 to:

- Guide the KHPA in the management of programmatic and non-programmatic health data;
- Ensure continued public support and investment in the use of this data to advance health policy;
- Disseminate the data in partnership with stakeholders; and
- Ask and answer important health policy questions pertaining to access, affordability, quality of health care and health status of Kansans.

Mr. Mavoori's testimony includes a listing of measures recommended by the Data Consortium (Attachment 9). The Data Consortium made the following recommendations:

- That the data be compiled from the recommended data sources (compilation has started);
- That the Kansas State Dashboard be based on the recommended measures and indicators (to be launched in January 2009);
- That recently collected data be available for use along with historic data to show baseline trends; and
- That the data compilation be supported by evidence-based interventions at both the policy and practice levels and that appropriate incentives are available for all stakeholders.

Mr. Mavoori indicated that the results of a data comparison to other states will be available by the end of January 2009. The comparison data provided by the Data Consortium will show how Kansas is progressing compared to previous years. Mr. Mavoori noted that the data will provide consumers with readily available information, allow for comparison and encourage patient safety. Mr. Mavoori stated that the implementation of the data interface will be "up and running" by the end of 2009. It was noted that the Kansas Insurance Department (KID) has a wealth of information available. The Data Consortium is working with KID to gain access to this information. Mr. Mavoori provided a listing of data measures recommended by the Data Consortium grouped into four major categories: access to care; health and wellness; quality and efficiency; and affordability and sustainability. The data will be classified into different tiers of information with Tier 1 including data such as vital statistics records and Medicaid records; Tier 2 including information such as Kansas Insurance Department records that have not been checked for integrity; and Tier 3 including data such as full-time equivalency (FTE) of health care providers and workers that is not currently collected.

Study of Bariatric Surgery for the Morbidly Obese (2008 HB 2672)

Dr. Andy Allison presented an overview of the study on Coverage for Bariatric Surgery (Attachment 10). Dr. Allison stated that the Health Care Commission (HCC) began considering coverage for bariatric surgery in 2006 with KHPA engaged in a statewide health reform initiative in 2007. In 2008, the HCC decided to cover preventive and non-invasive obesity treatments for 2008 under the State Employee Heath Plan (SEHP). The coverage provided in 2008 allows for non-surgical treatment of obesity, expanded coverage for consultation with a dietitian, and added coverage for prescription weight loss medications. Dr. Andy Allison reported that Kansas now has two Centers of Excellence for bariatric surgery as designated by the American Society for Bariatric Surgery and that Kansas has three certified centers to provide bariatric services to Medicare beneficiaries as designated by Centers for Medicare and Medicaid (CMS). Research evidence shows the positive health impact of bariatric surgery for the extremely obese. Dr. Allison indicated that the estimated cost of coverage for bariatric surgery in the SEHP could be as much as $15 million in the first year and would depend on the required pre-conditions for surgery. However, long-term savings to the state are anticipated. Also, Medicaid could provide additional coverage for bariatric surgeries.

KHPA recommendations concerning bariatric surgery include:

- Emphasizing the value of preventive care which has already begun in the State Employee Health Plan and which is being developed for the Medicaid program; and

- Developing recommendations to present to the HCC to cover bariatric surgery in the SEHP by using Medicare coverage as a starting point, by working with weight loss and surgical experts to target surgery for those who can benefit most and considering Medicaid coverage if funding is available.

Responding to questions from the Committee, Dr. Allison noted that some of the studies show that there is evidence of the need for second surgeries and some negative side effects of bariatric surgery. The Committee stated that the research is important, and that it might be important in future research to differentiate between gastric banding and gastric bypass surgery.

Linda Sheppard, Director, Accident and Health Division, Kansas Insurance Department, presented testimony on the impact of extending coverage for bariatric surgery in the Small Business Employer Group and High Risk Pool (Attachment 11).

Ms. Sheppard noted that KID conducted a survey of the 25 insurers licensed to sell small group coverage in Kansas, to determine the affordability of coverage in the small group market. The 13 insurers who responded to the survey were reluctant to provide a definitive response because of the absence of specific information regarding the amount and type of benefits to be provided and the criteria to be used to determine the medical necessity for bariatric surgery. The insurers were also reluctant to estimate the potential economic impact on premiums. However, the insurers estimated an impact on premiums in the small group market is in the range of approximately one to eight percent with an average of three percent and estimated an average benefit payment of $16,000. The actual amount billed by the providers was in excess of $6.5 million, with an average billed amount of $45,000 per procedure.

KID also requested and reviewed historical costs and benefits data for the KHIA High Risk Pool (HRP) concerning bariatric surgeries. Treatment of obesity is excluded from coverage under the KHIA policy. However it has been provided to members when treatment is determined to be medically necessary by KHIA's utilization review organization. From January 1, 2006, through September 30, 2008, KHIA paid benefits for bariatric surgery for nine members including both gastric

bypass and gastric banding, at a total cost of approximately $96,000. KHIA's consulting actuary reported that there has been no significant impact on member premiums over the past four plan years covering the nine surgery procedures. However, changes in the criteria and documentation currently used could have a significant impact on KHIA's costs if greater numbers of procedures were approved and performed.

In response to a question from the Committee, Craig VonAlzt, KID, indicated that small business groups do not have the flexibility to add some types of coverage to their policies. The Committee expressed concern that the insurance industry is controlling what can be covered by small businesses.

The Committee requested additional information on types of procedures that are covered by Medicare and advantage plans but are not covered by other types of insurance.

The meeting was recessed at 3:20 p.m.

Friday, November 21
Morning Session

HealthMapRx/Asheville Project

John Miall, Jr., Consultant to the American Pharmacists Association, presented an overview of the HealthMapRx/Asheville Project (Attachment 12). The Asheville Project is a voluntary, enhanced pharmaceutical care services program that began in 1998 in Asheville, North Carolina, and is designed to combat the effects of chronic diseases on the workforce. The mission is to improve the quality of consumer health outcomes. The program focuses on four chronic diseases: diabetes, cardiovascular health and hypertension, asthma and depression. The model centers on the patient and includes collaboration among all stakeholders: patients, employers, pharmacists, physicians, hospitals, other health care providers and health educators. The long-term outcomes include a decrease in direct medical costs for the patient. Physicians with patients in the program see their patients more often than before, but costs are reduced due to preventive care versus actual care needs. Asheville has had four consecutive years of a below zero increase in the cost of health care. The concept of the HealthMapRx Project is to drive down health costs by promoting preventive care. The program provides the tools for members to maintain better health and holds members accountable for their health.

Responding to a question from the Committee concerning how to start a pilot program in Kansas, Ben Blumb, American Pharmacists Association Foundation (AphA Foundation), indicated that the Foundation would provide the state assistance in developing a profile, selecting a patient population in a geographic area, and identifying a local heath care provider network. Mr. Blumb noted that 80 percent of sites that have adopted programs similar to Asheville's will see a reduction of costs in the first year and an increase in quality of life. The Committee expressed concern about up-front costs.

Chronic Care Management and the Medical Home Model

Dr. Marcia Nielsen provided an update on state initiatives concerning Chronic Care Management and the Medical Home Model for Kansas (Attachment 13). The KHPA ongoing chronic care management initiatives include:

- A $900,000 Centers for Medicare and Medicaid Services (CMS) health promotion grant for the disabled;
- The Enhanced Care Management pilot project in Wichita; and
- The State Employee Health Plan's HealthQuest Program.

Dr. Nielsen stated that In January 2008, Kansas was awarded $900,000 to improve preventive health for disabled Kansans enrolled in Medicaid. The grant is part of the $150 million approved by Congress for Medicaid Transformation Grants. These funds are to be used primarily for case management, specifically case managers. Dr. Nielsen noted that an enhancement of $250,050 from the State General Fund will be requested for FY 2010 because the federal grant does not fully fund the pilot project. Initially, approximately 1,700 disabled Kansans are to be served and the Authority proposes to expand the program to cover all eligible aged and disabled persons across the state.

The Committee requested a breakdown of how the enhancement of $250,050 would be spent.

Dr. Nielsen reported on the Enhanced Care Management Project that is designed to provide care management services to HealthConnect beneficiaries living in Sedgwick County. The project connects providers and beneficiaries through existing community resources. The project team includes a nurse, a social resources manager, and a physician. Consumers are Medicaid beneficiaries with chronic health conditions that have an increased probability for high-risk medical expenditures. As of February 2008, the pilot project had 194 actively enrolled beneficiaries. The Committee expressed concern about the effectiveness of the program and a need to see the actual cost savings of the project. The Committee also expressed concern that no pharmacists were included on the pilot project team.

Dr. Nielsen further explained the components of the HealthQuest Program that is available to members of the State Employee Health Plan. HealthQuest is administered on behalf of the state by Health Dialog through a three-year contract. Participants can access online programs and tools through the Dialog Center and HealthMedia. Approximately 16,300 participants have taken advantage of the online personal assessment program and over 9,000 individuals participated in the health wellness program. As a follow-up to these programs, HealthDialog made phone calls and mailings to participants to determine what health coaching assistance they needed. The Committee observed that there is a need to address the barriers to health care.

The Committee expressed concern about the effectiveness of the programs and requested further information on how participants in the programs were helped, how the participants responded and the effectiveness of the programs.

Dr. Nielsen stated that the Medical Home Model is part of reform policies defined in House Sub for Senate Bill 81 which was signed into law in June, 2008. The legislation directs KHPA to incorporate the use of the medical home delivery system within Kansas for participants of Medicaid, HealthWave, MediKan and the State Employee Health Plan. In addition, the legislation directs KHPA to work with the Kansas Department of Health and Environment (KDHE) and stakeholders to "develop systems and standards for the implementation and administration of a medical home in Kansas."

Wy/Jo Care Program

Dr. Mary Redmon, representing the Medical Society of Johnson and Wyandotte Counties Foundation, presented an overview of the Wy/Jo Care Program (Attachment 14). The Wy/Jo Care Program's mission is to enhance access to health care and improve the health status of the low-income, uninsured residents of Johnson and Wyandotte counties by partnering with safety net clinics to connect their patients with donated medical services. Dr. Redmon noted that one of the greatest strengths of the program is that it is physician-driven with over 200 physicians involved in the program. At this time, there are eight clinics, in Wyandotte and Johnson Counties, that participate in the program.

Responding to questions from the Committee, Dr. Redmon noted that there are plans to expand the program into other areas including dental care for pregnant women, physical therapy, and others. Dr. Redmon indicated that there are a large number of optometrists who provide services through the network. Blue Cross Blue Shield of Kansas City is also working with the program. With regard to protection for the physicians, Dr. Redmon reported that prior to receiving care, patients sign a form which indicates that they are receiving charity care and physicians are covered by the Tort Claim Act while providing charity care.

Wichita Center for Graduate Medical Education (WCGME) Funding Request to the Kansas Bioscience Authority (KBA)

Representative Landwehr updated the Committee members on the activities of the Physician Workforce and Accreditation Task Force (Attachment 15). Representative Landwehr stated that the Task Force is charged with determining how best to maintain accreditation of the graduate medical education programs sponsored by the University of Kansas School of Medicine, in particular the Wichita Center for Graduate Medical Education (WCGME) Program.

Penny L. Vogelsang, Chief Operating Officer, WCGME, presented an update on the funding request to the Kansas Bioscience Authority (KBA) for the WCGME Research Enhancement Initiative (Attachment 16). The proposal to KBA includes the development of a collaborative organization and infrastructure to support clinical and translational research that would:

- Increase the number of resident physicians with research training or experience, with the potential to translate research discoveries into practice and into the marketplace;

- Enhance existing clinical and translational research programs of the faculty, including opportunities for commercialization of the findings;

- Enhance research partnerships with other educational and clinical institutions in the area and throughout Kansas; and

- Increase collaboration with the commercial life sciences community in the region and throughout the state.

Jim Mitchell, Director, Heartland BioVentures and Investments, KBA, indicated that it is not the intent of the KBA to duplicate research being done in other environments, but to expand and develop outcomes in new areas. Dr. Mitchell noted that it was difficult in the beginning to tie the WCGME research proposal into the work of the KBA. To meet the accreditation requirements, basic

research needs to be established at WCGME. However, the research needs to tie into what the KBA can support from a funding aspect because of the KBA charter established by the Legislature. Ms. Vogelsang noted that it is difficult to get a commitment from research staff and make research sustainable because multiple-year funding was not authorized. There is also a concern about the availability of funding because of the current budget shortfall within the state.

Afternoon Session

Annual Report on the Children's Health Insurance Plans

Dr. Andy Allison presented an annual update on Children's Health Insurance Plans (Attachment 17). Dr. Allison noted that the insurance plans are administered through HealthWave, the state's program of managed care providing medical services to children and families eligible for Medicaid (Title XIX of the Social Security Act) and the State Children's Health Insurance Plan (SCHIP) (Title XXI of the Social Security Act). HealthWave services include:

- Physical health plans;
- Mental health and substance abuse plans; and
- Dental care, which is provided via fee-for-service.

HealthWave was created in January 1999 for the SCHIP population and expanded to include Medicaid managed care members. To be HealthWave eligible, the total countable income must not exceed the monthly Federal Poverty Level (FPL) standards based on the appropriate number of family members. Quality of care is measured using national recognized quality Healthcare Effectiveness Data Information Set (HEDIS), satisfaction surveys, and performance improvement projects. Dr. Allison stated that KHPA routinely monitors the quality and operational performance of all plans.

Responding to questions from the Committee, Dr. Allison reported that pharmacy claims are excluded from the performance results report. Information has not been shared with providers; however, information will be made available online for those providers who are interested. The Committee expressed a concern that the performance data is being collected but not being shared with providers or used for improvement.

The Committee requested a performance report on pharmacy claims.

Linda Steinke, State Director, UniCare Health Plan of Kansas, provided testimony on UniCare Health Plan (Attachment 18). Ms. Steinke stated that UniCare is committed to provide health care coverage to the State's most vulnerable population through the HealthWave program. They are currently serving over 51,000 members in both the HealthWave 19 and HealthWave 21 programs. UniCare serves all 105 counties in Kansas with staff in Topeka, Wichita, Garden City, and Colby. Unicare processes and pays claims on a daily basis to all providers. In the past year, the network commitment has grown in the field of primary care to include physicians, specialists, hospitals, ancillary providers, and pharmacies.

Bob Finuf, CEO, Children's Mercy Family Health Partners (CMFHP), provided an update on their activities (Attachment 19). CMFHP is a not-for-profit safety net health plan owned by Children's Mercy Hospitals and Clinics, a not-for-profit free standing pediatric health system based in Kansas City. Highlights from Mr. Finuf's testimony include:

- CMFHP began serving HealthWave recipients on January 1, 2007, and currently provide services to approximately 111,000 HealthWave recipients in the eastern two-thirds of the state. About 96,000 of the recipients served in Kansas are kids in the Title 19 Medicaid and Title 21 SCHIP programs;

- The provider network serving Kansas HealthWave has grown to over 1,650 primary care providers, about 3,050 specialist physicians and other providers, 111 hospitals, and 620 pharmacies;

- All performance information is shared with providers;

- CMFHP has partnered with providers, schools, community agencies, and other groups to expand health improvement programs;

- Implemented Provider and Community Councils throughout the state to get feedback on program development and operational improvements;

- Initiated a collaboration with the Kansas Learning Center for Health in Halstead to provide students with the tools they need to make better choices for a health future; and

- Working with the KHPA's Medical Home Stakeholder group to assist in implementation of the medical home initiative in Kansas.

The Committee expressed concern about allowing members to change from one plan to another on a monthly basis, which could be disruptive to the providers. Dr. Allison stated that KHPA is aware of the problem, and indicated that much of the switching is done early-on because many of the participants are auto-enrolled. KHPA is working with CMS to find a way to design the enrollment stage to eliminate much of the switching.

The Committee requested that KHPA provide a summary of members who are switching and the reason for the switching.

Cindy Peterson, Vice-President for Clinical Operations, Cenpatico Behavioral Health Systems, provided testimony on their experiences this year in managing behavioral health benefits for over 40,000 members enrolled in HealthWave 21 (Attachment 20). Particular areas of focus include:

- Access to care – developed and maintained a network of available, credentialed and contracted providers throughout the state including 26 community mental health centers, 28 facility providers, 449 group or solo providers including:

  - 50 physicians;
  - 19 ARNPs/RNs;
  - 95 PH.D./Psy.D;
  - 149 LCSWs; and
  - 136 other licensed clinicians.

- Improving quality of care – Increased outpatient visits by 17 percent over the prior year, ensure that members receive appropriate services at the least restrictive level of care, and take a strength-focused approach to case management that

considers the member's current resources, environment, treatment history and clinical needs;

- Demonstrating accountability – Improved consumer choice, brought accountability through measurable outcomes to the Kansas SCHIP program and maintained expanded access to care and services at a consistently lower cost than previously available; and

- Increasing consumer participation in directing care decisions.

Ms. Peterson noted that it is difficult to determine an appropriate way to share quality outcomes with providers. The Committee again expressed their concern in regard to the importance of sharing survey results and comments with providers.

Carla Deckert, Project Manager, Kansas HealthWave Clearinghouse and representative of MAXIMUS, provided testimony on the Kansas HealthWave Project which MAXIMUS operates under contract with KHPA (Attachment 21). Ms. Deckert stated that MAXIMUS was awarded its original contract competitively in August of 1998 to provide health care to children. Their current scope of work includes:

- Determining new eligibility for Title XXI (SCHIP);
- Completing yearly reviews for Title XXI customers;
- Providing screening and ancillary work for Title XIX customers;
- Completing requested changes on open Clearinghouse cases;
- Verifying citizenship and identify for Title XIX applicants;
- Providing both live and voice mail customer service assistance via a toll-free line; and
- Collecting and administrating premium payments for Title XXI customers.

During the past few years, MAXIMUS has converted case files and other information into digital image files to allow for greater transparency and access to information. MAXIMUS has also made changes to accommodate the new federal requirement to verify citizenship and identity of Medicaid recipients.

Responding to a question from a Committee member, Ms. Deckert noted that 100 percent of applications and reviews are processed in less than 30 days with most processed in seven to ten days.

In conclusion, Dr. Allison stated that KHPA believes it has a firm base and effective partnership to operate HealthWave across the state. Dr. Allison noted that data is being used to drive healthcare decisions and KHPA is committed to making the program stronger by sharing reviews publicly and holding contractors accountable.

Dr. Allison indicated that there is concern with how to progress with the non-HealthWave population. Outcomes information is limited for the fee-for-service population. The HealthConnect program is in place, but it is not a heavily-managed program. At this time, KHPA is pursuing how best to manage a program, how to address the fee-for-service population and develop a plan to work with a diverse Kansas population. Dr Allison stated that recommendations will be presented to the KHPA Board and the 2009 Legislature.

Committee Discussion regarding Committee Report Recommendations

Terri Weber, Kansas Legislative Research Department, provided an explanation of the process to fulfill the statutory requirement of submitting an Interim Committee Report to the 2009 Legislature. Ms. Weber noted that the Committee also has the authority to introduce legislation.

The Committee requested that the following information be included in the Interim Committee Report:

- That KHPA keep an open mind to all health reform opportunities and continue to look beyond premium assistance in identifying alternative ways to provide improved health services;
- That an automated Prior Authorization (PA) system be implemented for use by pharmacists to avoid delay or complications in getting a prescription covered through the Medicaid system;
- That the Committee is concerned that data collected by the KHPA on HealthWave service providers is not shared with the providers or used for improvement of services;
- That KHPA enter into dialogue with the HealthMapRx/Asheville Project and other interested parties to conduct a pilot program in a specified geographic area in Kansas. The dialogue should target the diabetes population and investigate the possibility of a delayed payment arrangement until Kansas has the resources to fund the pilot project;
- That the KHPA and the Kansas Insurance Department be thanked for their work on the bariatric surgery study; and
- That the KHPA be thanked for information and discussion regarding the data quality issue and that KHPA be requested to return to the Legislature as soon as possible with information on how to proceed with collection and utilization of health-related data in setting data-driven health policy.

Dr. Nielsen reminded the Committee that KHPA answers to the KHPA Board and does not proceed with any initiative without the authority of the KHPA Board.

The Legislative Research Department will compile a preliminary report and submit it to Committee members for input before finalization and publication.

Adjournment

The meeting was adjourned at 3:30 p.m.

Prepared by Shirley Jepson
Edited by Terri Weber and Kelly Navinsky-Wenzl

Approved by Committee on:

June 9, 2009

(Date)