Approved: February 21, 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 11, 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
Bobbi Mariani, Legislative Research Department
Susan Duffy, KLRD
Carolyn Long, Committee Assistant

Conferees appearing before the Committee:
Dr. Robert Moser, Secretary, Department of Health and Environment (Attachment #1)

Others attending:
See attached list.

Pam Scott, Executive Director, Funeral Directors Association, requested introduction of legislation which would address language in 65-1732 regarding disposal of unclaimed cremated remains and also the unclaimed cremated remains of veterans. *Moved by Senator Schmidt, seconded by Senator Reitz.*

The Chair welcomed Secretary Robert Moser, M.D., Kansas Department of Health and Environment. Dr. Moser presented the committee with a KanCare Update (Attachment #1). Long-run trends in Medicaid are driven by widespread increases in enrollment and spending per person. It is not "just the economy"—Kansas is in the midst of a sustained period of accelerated growth as baby boomers age. Enhanced federal match rate partially, and temporarily, disguised the scale of the deficit. As Medicaid expenditures grow it puts pressure on other programs.

Stakeholder involvement included: solicited ideas for reforms or pilots to curb growth, achieve long-term reform, and improve the quality of services in Medicaid; 60+ submissions with more than 100 proposals submitted in February 2011; three public forums this summer with 1,000 participants and more than 1,600 individual ideas; web survey generated about 200 additional responses; and stakeholder web conferences helped define issues and key concerns with emerging themes.

There are three population areas of concern: children, families and pregnant women who are a mobile population and move in and out of eligibility; the aged who incorporate a higher-than-

average proportion of Kansas seniors in institutions; and the disabled. Some of the problems with fragmentation are that spending is spread widely across service types, funding streams, state agencies, and providers and there is no uniform set of outcomes or measures for programs or providers.

Three major themes emerged from stakeholders: integrated, whole-person care which includes aligning financing around care for the whole person, patient-centered medical homes, and enhancing health literacy; preserving independence and creating a path to independence which involved removing barriers to work, aligning incentives among providers and beneficiaries and delaying or preventing institutionalization; and alternative access models which would utilize technology and non-traditional settings and thinking creatively about who could deliver care.

Secretary Moser then switched the focus of his presentation to the administration's implementation of KanCare. Giving background information, Dr. Moser said that on November 8, Governor Sam Brownback announced the plan to reform Medicaid in Kansas. The plan called for the implementation of an integrated care system called KanCare whose goals were to improve health outcomes and to bend the cost curve down over time while providing no eligibility or provider cuts. Kansas will seek a global waiver from the federal government to maximize flexibility in administering the Medicaid program for the benefit of all Kansans. The waiver request will mirror the board flexibility sought by many other states facing challenges similar to Kansas.

KanCare's goal is to provide Person-Centered Care Coordination wherein the state will leverage private sector innovation to achieve public goals by issuing a Request for Proposal (RFP) targeting three statewide KanCare contracts; population-specific and statewide outcomes measures will be integral to the contracts and will be paired with meaningful financial incentives; and reforms that explicitly call for creation of health homes, with an initial focus on individuals with a mental illness, diabetes, or both, and aging and disability resource centers. KanCare RFP's encourage contractors to use established community partners, including hospitals, physicians, community mental health centers (CMHCs), primary care and safety net clinics, centers for independent living (CILs) area agencies on aging (AAAs), and community developmental disability organizations (CDDOs). Safeguards for provider reimbursement and quality are included. The state will create a contractual obligation to maintain existing services and beneficiary protections as well as services for individuals residing in state ICF-MR facilities to continue being provided outside these contracts.

Home and Community Based Services include long-range changes to the delivery system by aiding the transition away from institutional care and toward services in the homes and communities including institutional and long-term care in person-centered care coordination means KanCare contractors will take on the risk and responsibility for ensuring that individuals

are receiving services in the most appropriate setting; that outcome measures will include lessening reliance on institutional care and that reforms also include helping nursing facilities build alternative HCBS capacity.

Services for Kansans with developmental disabilities will continue to utilize the statutory role of CDDOs but their inclusion in KanCare means the benefits of care coordination would be available to them. Contractors will be accountable for functional as well as physical and behavioral health outcomes. The DD Reform Act will continue to govern DD service provisions.

Governor Brownback proposes to form a 15 member advisory council comprised of persons with disabilities, seniors, advocates, providers and other interested Kansans to provide ongoing counsel on implementation of KanCare. Additionally, managed care organizations will be required to create a member advisory committee to receive regular feedback; include stakeholders on the required Quality Assessment and performance Improvement Committee; and have member advocates to assist other members who have complaints or grievances.

The Pay for Performance (P4P) program identifies six operational measures in the first contract year and 15 quality of care measures in years two and three which are tied to monetary incentives. The state will withhold three to five percent of the total capitation payments to MCOs until certain quality thresholds are met. Quality thresholds will increase each year to encourage continuous quality improvement. The measures chosen for the P4P program will allow the State to place new emphasis on key areas, such as life expectancy improvements for people with disabilities, encouraging nursing facilities to meet person-centered care standards, and shifting resources to community-based care and services. The P4P also adds new performance goals for certain quality indicators that were previously measured, such as the National Outcomes Measures for behavioral health. The State has also included measures in the P4P program which will strengthen performance expectations for employment opportunities for people with disabilities.

Based on a conservative baseline of 6.6% growth in Medicaid without reforms, the outcomes-focused, person-centered care coordination model executed under the RFP is expected to achieve savings of $853 million (all funds) over the next five years.

To better coordinate KanCare services, the Administration has proposed a realignment of the state's health and human agencies. Those impacted are Kansas Department on aging (DOA), Department of Health and Environment (KDHE), and Department of Social and Rehabilitation Services (SRS). Key points are to align and sustain programs, address inefficiencies, decrease the number of agencies dealing with Medicaid, not reduce staff or funding, and foster an environment in which each agency can more clearly focus on its mission and improve coordination across services and programs.

CONTINUATION SHEET

The minutes of the Public Health and Welfare Committee at 1:30 p.m. on January 11, 2012, in Room 546-S of the Capitol.

The Department on Aging will add disability services to its mission and will gain oversight of all Medicaid waivers and be responsible for mental health, substance abuse, and state hospitals. Programs moving from SRS to this new agency are Medicaid waivers, mental health, substance abuse, and state hospitals/institutions.

SRS will transform into an agency focus solely on services for children and family issues and renamed the Department for Children and Families.

The Kansas Department of Health and Environment's Division of Health Care Finance has been charged with KanCare finance and oversight with the core public health and environmental regulatory functions will remain at KDHE (Attachment #1).

Regarding global waivers, Secretary Moser said they were working with a consultant to develop the request and will keep the committee informed as to its status. He also indicated that they looked at other states with managed care; pulling from their programs areas that would be successful in Kansas regarding the unique whole person approach. He acknowledged that it is very daunting who to contact at the state level for assistance and hopes that the streamlining of agencies will rectify this situation.

The Chair thanked Dr. Moser for his appearance and asked if it would be possible for either himself or one of his staff return tomorrow to answer further questions from the Committee. Secretary Moser said he would be delighted to return the following day.

The next meeting of the committee is January 12, 2012 and the committee was reminded that the meeting would commence at 1:00 p.m in Room 548-S.

The meeting was adjourned at 2:30 p.m.