Approved: 2-1-94
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on January 26, 1994 in Room 526-S of the Capitol.

All members were present except: Senator Salisbury, Excused

Committee staff present: Norman Furse, Revisor of Statutes
William Wolff, Legislative Research Department
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:
Donna Whiteman, Secretary, SRS
Marlin L. Rein, University of Kansas Medical Center
Dannie M. Thompson, M.D., Wyandotte County
Sister Ann Marita Loosen, President and CEO, Providence Medical Center, KCK
Ed Beasley, Director, Wyandotte County Health Department
Margaret Daly, Wyandotte County Health Department

Others attending: See attached list

A review of Medicaid Managed Care in Wyandotte County

The Chair called attention to 1993 **SB 119** which established pilot projects for managed care in two counties in Kansas, and a report from Legislative Research Department that noted during the 1993 Omnibus Appropriations process a proviso was attached that referenced a managed care project at the KU Medical Center. There was no indication that it was legislative intent all Medicaid patients in Wyandotte County be directed to KUMC. (Attachment 1)

Donna Whiteman, Secretary, SRS, addressed the Committee and noted that SRS was directed through **SB 119** to establish Medicaid managed care pilot projects in the state - Sedgwick County, a county with a population of less than 100,000, and the 1993 Omnibus Appropriation bill instructed that a third pilot project be implemented at the University of Kansas Medical Center and all be operational July 1, 1995. Written testimony listed members of the task force as well as the number of issues the task force would be addressing. (Attachment 2)

Secretary Whiteman noted they have seen increases in the Medicaid budget from $321 million in 1989 to $703 million today -- 60% of that money comes from the federal government and 40% from state general fund resources. The statute provides that the Secretary of SRS may appoint a task force to study this issue. Secretary Whiteman commented that in order for managed care to work, there has to be provider and community participation and that managed care moves SRS from a claims processing agency to negotiating with providers up front and designates services for a fixed rate. In the Medicaid program today, SRS processes 21,000 payments every day to providers throughout the state of Kansas, and no direct medical care is provided other than what they contract with physicians, hospitals, pharmacists and other medical providers.

In answer to a member's question if there was ever any intent from SRS in implementing the proviso regarding all the Medicaid patients in Wyandotte County who currently are being treated with a variety of providers in that county that all of those Medicaid patients go to the KUMC, Secretary Whiteman commented no, and that it was her understanding the legislation not direct her to do that nor have a preference for the Med Center. She noted that this concern has been discussed with the task force, and also someone will be asked to serve on the task force from the Med Center. SRS has recently hired a graduate from Harvard to help with the implementation of the pilot project who has background in managed care. The Chair requested a biography be provided on the new staff person.

Marlin L. Rein, KUMC, addressed the Committee and copies of his remarks were distributed to the Committee. The first issue addressed the questions that have been raised relative to the manner in which the Legislature directed SRS to implement the managed care pilot project, the second issue related to the impact of a pilot project at the Med Center that was added in the Omnibus Appropriations bill, and the third concern was that the Med

Center not be viewed as harming the network of health care providers or lessen the quality or quantity of services available to Medicaid clients. Mr. Rein noted that as long as there is an expectation by the Legislature that KUMC institute such a pilot, KUMC has no choice but to attempt to comply. (Attachment 3)

Mr. Rein commented that consultants readily identified some of the inherent problems KUMC will have to deal with in trying to survive in the area of managed care and as a state teaching institution. He noted that the legislature has been very supportive in providing KUMC latitude to function in a more competitive way, but there still are limitations. He noted there are costs associated with a teaching institution, and in a managed care environment the key is to be competitive, and if KUMC is expected to be totally self-supporting as a hospital and still incur those costs, KUMC will be at a disadvantage.

Dannie M. Thompson, M.D., private practice in Kansas City, Kansas since 1968, appeared before the Committee and expressed his concern and frustration with the concept of a Medicaid Managed Care project for Wyandotte County and recommended deletion of the managed care project from the bill. (Attachment 4)

Sister Ann Marita Loosen, President and CEO of Providence Medical Center, KCK, appeared before the Committee in her capacity as one of the co-chairs of the Managed Care Advisory Committee for Wyandotte County, and expressed her concern of information received by hospital providers of **HB 2047** and its policy recommendation that the Medicaid Pilot Project for Wyandotte County essentially stated that the University of Kansas Medical Center was to be the sole provider for all hospital and physician services. Sister Ann Marita commented that they believe a medicaid capitation plan can be devised that would be effective and contain the principles necessary to protect the interests of the medicaid eligible. She also recommended introduction of legislation that would request SRS would draw upon the wealth of experience available from the two community hospitals in Wyandotte County as well as its physician providers and KUMC. (Attachment 5)

Ed Beasley, Wyandotte County Health Department, appeared before the Committee and submitted written testimony expressing concern regarding KUMC being chosen as the managed care project in Wyandotte County and requested legislation be introduced to amend this project. (Attachment 6)

In answer to a member's question to Secretary Whiteman if she thought new legislation was required or if the issue could be handled through SRS, Secretary Whiteman commented managed care in Kansas should be an open, community based process, and a compromise is needed in Wyandotte County between the Med Center, community providers and hospitals. It was noted that if there was new legislation, the same process would take place as before. During Committee discussion it was noted that better communication is needed between the University of Kansas Medical Center, Wyandotte County Health Department, SRS and the task force. One of the real concerns is that managed care has not been clearly defined.

Margaret Daly, Wyandotte County Health Department, suggested the plan should be called the Wyandotte County Plan. She noted that SRS was directed to work with the Medical Center to establish a managed care plan, but not exclusively called the KU Plan. Ms. Daly commented it was their understanding that patients who already go to the Medical Center would be part of this managed care plan.

In answer to a member's question regarding the fiscal impact on the Wyandotte County Health Department's budget as a result of this legislation, Mr. Beasley noted they would lose approximately $844,000 annually. In regard to the pilot project in a county of less than 100,000, Secretary Whiteman noted there has been no money appropriated for this project to date.

Question was asked by the Chair if those entities would be interested in managed care being expanded, and such managed care being a Wyandotte County community project which would have the providers in Wyandotte County collectively bid for providing Medicaid on a managed care capitated system. Dr. Thompson commented the proviso tried to identify the managed care plan as a Wyandotte County plan, and would like to have that plan deleted and start over with new legislation. It was noted by a member that more legislation is not needed, and those parties involved in Wyandotte County should work with SRS to resolve the problem.

The meeting was adjourned at 11:30 a.m.

The next meeting is scheduled for January 27, 1994.

GUEST LIST

COMMITTEE: SENATE PUBLIC HEALTH & WELFARE DATE: 1-26-94

NAME	ADDRESS	COMPANY/ORGANIZATION
Margaret Daly	619 N NW KCKs.	Wyandotte Co Health Dept
Robert Harder	LSOB	KDHE
Tajuah J. Hudson	3901 Rainbow, KCK	KU Medical Center
Chip Wheelen	Topeka	KS Med. Soc.
Lynn Rose	Topeka	Senate Staff
Dennis M Thompson	31 N 12th St KCKS 66101	MD.
KEITH R LANDIS	TOPEKA	CHRISTIAN SCIENCE COMM. ON PUBLICATION FOR KS
Rep. Pat Pettey		Kansas House
Michelle Peterson	Topeka	PMA
David Till	Dallas	Zeneca
Peter Ann Moreta	8929 Parallel Parkway	KC. Ks 66112
Reid F Holbrook	757 Armstrong KCK	Atty.
CARY McCLURE	51 N. 12th, K.C. KS.	Bethany Med CNTR
WAYNE KUTZ	51 N 12 St KCK	BETHANY MED CENTER
Lindsey Chalfant	Topeka	Sen. Salisbury
Wayne Sims	4300 Brenner Dr. KCKs	Kaw Valley Ctr.
Anne Roberts	4300 Brenner Dr KCK	Kaw Valley Ctr.
David Norris	E310 Kornish Sq. Lawrence	Intern for Rep. Pettey
Ann Carlin Ozegovic	815 Arkansas - Lawrence	Senator Jones Sec.

STATE OF KANSAS

RICHARD W. RYAN,
DIRECTOR
BEN F. BARRETT,
ASSOCIATE DIRECTOR
ALAN D. CONROY
CHIEF FISCAL ANALYST

STAFF—
LEGISLATIVE COORDINATING COUNCIL
INTERIM COMMITTEES
STANDING COMMITTEES
LEGISLATIVE INQUIRIES

THE LEGISLATIVE RESEARCH DEPARTMENT
300 W. TENTH—ROOM 545-N
PHONE: (913) 296-3181/FAX (913) 296-3824
TOPEKA, KANSAS 66612-1504

January 21, 1993

Dear Senator Praeger:

Enclosed is the documentation you requested regarding recommendations by the Appropriations and Ways and Means Committees at the close of the 1993 Session regarding Medicaid managed care pilot project.

The first document is page 27 of the bill explanation for the Omnibus Appropriations Bill (S.B. 437). This is the document that was used on the floor of both houses to explain the Omnibus Appropriations Bill. **ITEM No. 18** refers to the managed care projects and includes a recommendation that SRS initiate a project at the University of Kansas Medical Center.

The second document is a copy of the relevant pages of the SRS Subcommittee report, which basically forms a record of budget action on SRS during the 1993 Session. Item No. 16 on the bottom of page 34 and the top of page 35 specifically address the Omnibus recommendation.

No language was placed in any appropriations bill regarding these projects.

If I can be of further assistance, please contact me.

Laura Howard
Senior Fiscal Analyst

Senate PH&W
attachment #1
1-26-94

Senate Bill No. 437 Senate Recommendations	Sub. Senate Bill No. 437 House Recommendations	Conference Committee Recommendations
14. Concur with Governor's Budget Amendment No. 2 to delete $90,530 from the State General Fund in FY 1993 as a technical adjustment to the General Assistance KanWork program.	14. Concur.	14. Concur.
15. Concur with Governor's Budget Amendment No. 2 to shift funding of capital improvement projects for buildings rented by SRS on the Topeka State Hospital grounds from the Topeka State Hospital Budget to SRS in FY 1994. This adds $135,788 in rental surcharge funds to the SRS budget and will allow the agency to claim $183,713 in federal matching funds.	15. Concur.	15. Concur.
16. Concur with Governor's Budget Amendment No. 2 to allow the expenditure of additional federal funds totaling $306,742 in FY 1993 and FY 1994 for substance abuse capacity expansion.	16. Concur.	16. Concur.
17. Concur with Governor's Budget Amendment No. 2 to delete $91,996 in FY 1994 from federal Community Youth Block Grant funds. This grant was not renewed.	17. Concur.	17. Concur.
18. Shift $468,633 from the State General Fund ($1,148,188 All Funds) in FY 1994 from regular medical assistance to state operations and add eight special project positions for planning and implementation of the pilot Managed Care projects recommended in S.B. 119, as well as a project at the University of Kansas Medical Center. This shifts funding saved in medical assistance through converting three specialty hospitals to the DRG system effective October 1, 1993.	18. Concur with the shift of funding from regular medical assistance, but recommend an additional reduction of $146,367 from the State General Fund ($351,812 All Funds) in medical assistance based on changing reimbursement to three specialty hospitals effective July 1, 1993. Also, add 8.0 FTE positions for managed care.	18. Concur, but recommend the additional staff be special project positions.
19. Add $9,430 in FY 1993, and $37,600 in FY 1994 in accordance with an Executive Directive regarding a new federal teen parent grant.	19. Concur.	19. Concur.

SUBCOMMITTEE REPORT

Agency: Social and Rehabilitation Services **Bill No.** 2047, 2122, 437 **Bill Sec.** 2

Analyst: Howard **Analysis Pg. No.** 542 **Budget Page No.** 530

Expenditure	Agency Req. FY 94	Governor's Rec. FY 94	House Sub. Adjustments
All Funds:			
State Operations	$ 251,376,577	$ 213,255,017	$ (12,505,120)
Local Aid	69,610,613	61,809,212	2,725,500
Other Assistance	1,083,190,497	990,200,803	(20,373,418)
Subtotal -- Operating	$ 1,404,177,687	$ 1,265,265,032	$ (30,153,038)
Capital Improvements	16,657,656	4,002,648	--
TOTAL	$ 1,420,835,343	$ 1,269,267,680	$ (30,153,038)
State General Fund:			
State Operations	$ 104,010,489	$ 86,898,538	$ (7,691,793)
Local Aid	66,002,398	49,174,617	689,557
Other Assistance	341,901,740	282,497,384	(8,998,220)
Subtotal -- Operating	$ 511,914,627	$ 418,570,539	$ (16,000,456)
Capital Improvements	6,957,759	73,313	--
TOTAL	$ 518,872,386	$ 418,643,852	$ (16,000,456)
FTE Positions	4,375.2	3,903.5	(38.0)

Agency Request/Governor's Recommendation

The SRS FY 1994 operating budget request is an increase of $204.8 million from the revised FY 1993 estimate, including a State General Fund increase of $128.6 million, and a reduction from the SRS Fee Fund of $20.4 million. The request includes funding for 419.5 FTE new positions for a total of 4,375.2 FTE positions. The reduction from the SRS Fee Fund reflects the spenddown of excess disproportionate share funds earned in FY 1992 in the FY 1993 budget (the "fifth quarter"), so that in FY 1994, no excess carryforward funds are available. The agency's budget request does not assume expenditure of any of the $50.0 million in retroactive disproportionate share funds set aside by the 1992 Legislature in a Social Services Contingency Fund.

The Governor recommends operating expenditures of $1.3 billion for SRS in FY 1994, an increase of $79.9 million (6.7 percent) from the FY 1993 recommendation. The recommendation is a reduction of $138.9 million from the agency request. The Governor does not recommend funding for any new positions in FY 1994; in fact, the Governor recommends a reduction of 13.5 FTE positions in concert with her recommendation to reduce by half the size of the Comprehensive Screening Unit at Topeka State Hospital. The Governor's recommendation is an increase of $42.6 million in State General Fund dollars from FY 1993, and reflects a reduction of $16.1 million from the SRS Fee Fund. The reduction from the Fee Fund reflects the spenddown of excess disproportionate share funds in FY 1993. The Governor's recommendation from the SRS Fee Fund includes

6. Concur with Governor's Budget Amendment No. 2 to add $28,364 in federal supported employment funds in FY 1994 based on revised estimates of federal receipts.

7. Concur with Governor's Budget Amendment No. 2 to delete $34,965 from the State General Fund and add $2,548,332 in Medicaid funding in FY 1994 based on revised foster care caseload estimates. Also, add a proviso requesting the Secretary of SRS consider restoring foster care programs at Parsons State Hospital and Winfield State Hospital and Training Center in a similar fashion as available at the Kansas Neurological Institute.

8. Concur with Governor's Budget Amendment No. 2 to add $91,661 from the State General Fund ($139,770 All Funds) in adoption support in FY 1994 based on revised caseload estimates.

9. Concur with Governor's Budget Amendment No. 2 to correct the expenditure limitation on the Juvenile Justice and Delinquency Fund in FY 1994. Also, shift funding between two accounts to correct a technical adjustment in H.B. 2047, and correct fee fund posting errors in H.B. 2087.

10. Concur with Governor's Budget Amendment No. 2, to increase Child Care and Development Block Grant expenditures by $1,448,690 in $1,373,367 in FY 1994 to allow the agency to expend funds available from prior fiscal years. Also, make technical adjustments to realign State General Fund and Social Service Block Grant funds in the agency's budget.

11. Concur with Governor's Budget Amendment No. 2 to add $177,767 from the State General Fund ($1,050,766 All Funds) in FY 1994 for Medicaid Management Information System federal mandates.

12. Concur with Governor's Budget Amendment No. 2 to shift $258,445 from the State General Fund ($1,908,329 All Funds) from FY 1993 to FY 1994 to reflect changes in the scheduling of certain system upgrades to the Medicaid Management Information System.

13. Concur with Governor's Budget Amendment No. 2 to shift funding of capital improvement projects for buildings rented by SRS on the Topeka State Hospital grounds from the Topeka State Hospital Budget to SRS in FY 1994. This adds $135,788 in rental surcharge funds to the SRS budget and will allow the agency to claim $183,713 in federal matching funds.

14. Concur with Governor's Budget Amendment No. 2 to allow the expenditure of additional federal funds totaling $306,742 in FY 1994 for substance abuse capacity expansion.

15. Concur with Governor's Budget Amendment No. 2 to delete $91,996 in FY 1994 from federal Community Youth Block Grant funds. This grant was not renewed.

16. Shift $468,633 from the State General Fund ($1,148,188 All Funds) in FY 1994 from regular medical assistance to state operations and add eight special project

positions for planning and implementation of the pilot Managed Care projects recommended in S.B. 119, as well as a project at the University of Kansas Medical Center. Also delete $146,367 from the State General Fund ($351,812 All Funds) in medical assistance savings based on changing reimbursement to three specialty hospitals effective July 1, 1993.

17. Add $57,600 in FY 1994 in accordance with an Executive Directive regarding a new federal teen parent grant.

18. Add a proviso prohibiting the Secretary from making any expenditures for or on behalf of the SRS Drug Utilization Review Committee unless the Committee operates in compliance with the Kansas Open Meetings Act. The proviso would allow the Committee to recess into executive session when discussing identifiable patients or providers.

19. Shift a total of $2.5 million in expenditures for the KanWork program from the State General Fund to the EDIF.

20. Delete a total of $2.0 million from the State General Fund in medical assistance, with service modifications left to the discretion of the Secretary.

21. Delete $500,000 from the State General Fund in FY 1994 for an expansion of the Medicaid waiver for the mentally retarded and developmentally disabled to provide medical and therapeutic services. This funding was approved in H.B. 2047; however, although this funding was not vetoed by the Governor, the veto message on H.B. 2047 indicates that the Governor has directed the Secretary not to undertake this program expansion.

22. Delete $500,000 from the State General Fund in FY 1994 for special purpose grants for the mentally retarded and developmentally disabled. The intent of this recommendation is that the Secretary apply for an expansion of community placements under the HCBS waiver and shift eligible clients currently served entirely from State General Fund dollars to Medicaid funding. The reduction assumes approval of an expanded waiver as of January 1, 1994.

23. As a technical adjustment to reflect funding shifted from Winfield State Hospital, add $87,665 from the State General Fund and 2.0 FTE positions.

24. Concur with the reinsertion of certain provisions vetoed by the Governor in H.B. 2047, including:

    a. Transfer $500,000 from the ICF Revolving Fund to the Mental Retardation Developmental Disability Provider Revolving Fund. Delete the transfer of funding from the ICF Revolving Fund to the State General Fund recommended in H.B. 2047.

    b. Transfer a total of $25.0 million from the Social Service Contingency Fund to the SRS Fee Fund as recommended by the Governor for SRS operating expenditures. Add $325,000 from the SRS Fee Fund for one-time place-

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Donna L. Whiteman, Secretary

Senate Public Health and Welfare
Testimony Regarding SRS Managed Care Pilot Projects
January 26, 1994

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The SRS Mission Statement:
"The Kansas Department of Social and Rehabilitation Services empowers individuals and families to achieve and sustain independence and to participate in the rights, responsibilities and benefits of full citizenship by creating conditions and opportunities for change, by advocating for human dignity and worth, and by providing care, safety and support in collaboration with others.

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Madam Chair and members of the Committe I thank you for this opportunity to address you regarding the SRS Managed Care Pilot Projects.

Social and Rehabilitation Services was directed through Senate Bill 119 to establish Medicaid managed care pilot projects in three areas. Sedgwick County, a county with a population of less than 100,000 and the 1993 Omnibus Appropriations Bill committee minutes instruct that a third pilot project be implemented with the University of Kansas Medical Center. The pilots are to be operational by July 1, 1995. The managed care programs for the Medicaid population were discussed during the 1993 legislative session as a possible way to increase access to primary and preventive health care, improve the quality of medical care and to reduce the rate of growth in expenditures of the Medicaid budget.

The pilot projects for Medicaid managed care offer an opportunity for new ideas and concepts to be tested. With national health care reform becoming a reality, it is even more prudent for Kansas to pilot more than one type of health care delivery system. The goal is to have a health care delivery system that works for both providers and recipients.

There have been initial community meetings with interested persons in Wichita and Kansas City. The groups expressed their concerns and provided input on the managed care pilot projects. As with any new program which requires major changes in policy and reimbursement, providers in the communities involved are expressing many reservations and anxieties regarding implementation of the managed care pilot projects. A successful managed care program is greatly dependent on community provider support in the overall strategy and development of the pilot projects. SRS must continue to take the time now to develop and enhance public relations with providers and recipient groups to build support for the managed care pilot projects.

The Managed Care Task Force has met twice and will continue to meet monthly. A copy of the membership list is attached.

SRS staff are working closely with the community work groups and the Managed Care Task Force to facilitate the successful and effective implementation of managed care in Kansas. SRS plans to meet the July 1, 1995 deadline for implementation of the pilot projects, while ensuring the issues are addressed thoroughly.

Donna L. Whiteman
Secretary

Senate PH&W
attachment #2
1-26-94

MANAGED CARE TASK FORCE

Legislators -

The Honorable Carol Dawson
458 East 3rd
Russell KS 67665

The Honorable Carol Sader
8612 Linden Drive
Prairie Village KS 66207

The Honorable Bill Wisdom
1915 So. 29th St. Ct.
Kansas City KS 66106

The Honorable Doug Walker
212 1st Street
Osawatomie KS 66064

The Honorable Melvin Neufeld
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The Honorable Kathleen Sebelius
224 Greenwood Avenue
Topeka KS 66606

The Honorable JoAnn Flower
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The Honorable Barbara Lawrence
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The Honorable Sandy Praeger
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The Honorable Janice Hardenburger
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Topeka KS 66606

Joseph Meek, M.D.
Dean, KU School of Medicine
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Wichita KS 67214-4976

Hospital -

Mental Health Center -

Don Schreiner, Director
Pawnee Mental Health Center
2001 Claflin
Manhattan KS 66502

Consumer/Advocate -

Rita Cortez
%SRS Topeka Area Office
235 So. Kansas Avenue
Topeka KS 66601

Gordon Criswell
Office of the Disabled
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Kansas City KS 66101

Managed Care -

Cheryl Dillard
Public Affairs Manager
Kaiser Foundation Health Plan of
Kansas City, Inc.
10561 Barkley, Suite 200
Overland Park KS 66212

(Published in the Kansas Register, April 29, 1993.)

SENATE BILL No. 119

AN ACT providing for the establishment of a pilot project to provide medicaid services in certain areas of the state through a system of managed care.

Be it enacted by the Legislature of the State of Kansas:

Section 1. (a) Subject to applicable federal guidelines and regulations and the provisions of appropriations acts, the secretary of social and rehabilitation services shall negotiate and enter into contracts for a pilot project to be conducted in two counties of this state during the fiscal year ending June 30, 1995. The pilot project under this section shall be conducted in Sedgwick county and in a county having a population of less than 100,000 people as specified by the secretary of social and rehabilitation services and the task force or task forces established under subsection (e). The pilot project shall be conducted to provide medicaid services through a system of managed care for Kansas medicaid eligible residents on the basis of a described set of such services to a predetermined population as prescribed by the contracts. No contract entered into under this section shall be subject to the competitive bid requirements of K.S.A. 75-3739 and amendments thereto. The services to be provided for such residents under the contracts shall be provided through a system of managed care as specified in the contracts.

(b) The contract may be entered into by the secretary with a single provider or with a contracting agency to provide such services through a group of qualified health care providers, or both, within the areas of Kansas specified for the pilot project under this section. In determining the location of the pilot project located in a county other than Sedgwick county and the area in which such services shall be provided, the secretary and the task force or task forces shall consider the availability of health care providers and their willingness to participate in such pilot project at the time the pilot project is to commence under the contract.

(c) If the secretary of social and rehabilitation services determines that waivers from program or other requirements of the federal government are needed to carry out the provisions of this section and to maximize federal matching and other funds with respect to the pilot project authorized under this section, the secretary shall apply to the federal department of health and human services, or other appropriate federal agency, for such waivers. If the secretary determines that waivers are needed, the pilot program established under this subsection shall not commence until such waivers are granted by the appropriate federal agency.

(d) The secretary shall submit a preliminary report on the results of the pilot project to the committee on ways and means of the senate and the committee on appropriations of the house of representatives at the beginning of the 1994 regular session of the legislature. The secretary shall submit additional reports and information regarding the pilot project annually for the next four years.

(e) The secretary of social and rehabilitation services shall appoint a task force or task forces concerning the pilot project and including local representation to advise the secretary on matters relating to the implementation of the pilot project established under this section. The task force or task forces shall make findings and recommendations concerning the pilot project established under this section and shall report such findings and recommendations to the joint committee on health care decisions for the 1990's and to the legislature on or before the commencement of the 1994 legislative session. Members of the task force or task forces shall not be paid compensation, subsistence allowances, mileage or other expenses as otherwise may be authorized by law for attending meetings, or subcommittee meetings, of the task force or task forces.

Sec. 2. This act shall take effect and be in force from and after its publication in the Kansas register.

(Published in the Kansas Register, April 29, 1993.)

SENATE BILL No. 402

AN ACT concerning medical care facilities; relating to ambulatory surgical centers; amending K.S.A. 65-425 and repealing the existing section.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 65-425 is hereby amended to read as follows: 65-425. As used in this act: (a) "General hospital" means an establishment with an organized medical staff of physicians; with permanent facilities that include inpatient beds; and with medical services, including physician services, and continuous registered professional nursing services for not less than 24 hours of every day, to provide diagnosis and treatment for patients who have a variety of medical conditions.

(b) "Special hospital" means an establishment with an organized medical staff of physicians; with permanent facilities that include inpatient beds; and with medical services, including physician services, and continuous registered professional nursing services for not less than 24 hours of every day, to provide diagnosis and treatment for patients who have specified medical conditions.

(c) "Person" means any individual, firm, partnership, corporation, company, association, or joint stock association, and the legal successor thereof.

(d) "Governmental unit" means the state, or any county, municipality, or other political subdivision thereof, or any department, division, board or other agency of any of the foregoing.

(e) "Licensing agency" means the department of health and environment.

(f) "Ambulatory surgical center" means an establishment with an organized medical staff of *one or more* physicians; with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; with continuous physician services ~~and~~ *during surgical procedures and until the patient has recovered from the obvious effects of anesthetic and at all other times with physician services available whenever a patient is in the facility; with continuous* registered professional nursing services whenever a patient is in the facility; and which does not provide services or other accommodations for patient to stay ~~overnight~~ *more than 24 hours. Before discharge from an ambulatory surgical center, each patient shall be evaluated by a physician for proper anesthesia recovery. Nothing in this section shall be construed to require the office of a physician or physicians to be licensed under this act as an ambulatory surgical center.*

(g) "Recuperation center" means an establishment with an organized medical staff of physicians; with permanent facilities that include inpatient beds; and with medical services, including physician services, and continuous registered professional nursing services for not less than 24 hours of every day, to provide treatment for patients who require inpatient care but are not in an acute phase of illness, who currently require primary convalescent or restorative services, and who have a variety of medical conditions.

(h) "Medical care facility" means a hospital, ambulatory surgical center or recuperation center.

(i) "Rural primary care hospital" shall have the meaning ascribed to such term under K.S.A. 65-468 and amendments thereto.

(j) "Hospital" means "general hospital," "rural primary care hospital," or "special hospital."

(k) "Physician" means a person licensed to practice medicine and surgery in this state.

Sec. 2. K.S.A. 65-425 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the Kansas register.

2-4

GOVERNOR'S BUDGET RECOMMENDATION BY CATEGORY OF SERVICE
MEDICAL ASSISTANCE

Program / Service	FY 1993 Actual	FY 1994 GBR	FY 1995 GBR
Regular Medical Care			
Inpatient Hospital	153,748,362	157,902,368	175,346,175
Outpatient Hospital	14,804,998	16,527,077	18,007,643
Ambulatory Surg Ctr	344,208	384,750	419,705
Physician	61,967,361	68,287,862	74,596,157
Pharmacy	58,588,151	67,142,261	74,877,874
Vision	2,532,993	2,799,175	3,046,571
Dental	7,033,120	6,801,670	7,417,234
Local Health Dept	1,851,970	2,859,772	3,034,121
Home Health Agency	10,289,964	12,206,533	13,849,134
Non–CMHC Part Hosp	2,049,537	2,496,698	2,869,690
CMHC –FFP & Certified State Match	13,973,839	15,814,265	16,975,898
Psychologist	1,279,619	1,426,602	1,571,859
Lab & X–Ray	4,747,759	5,227,002	5,737,256
Transportation	2,616,946	3,004,728	3,343,878
Chiropractor	3,520	3,520	3,520
Podiatrist	24,615	24,618	24,618
Hearing Services	326,303	372,907	415,562
Supplies	4,767,638	5,634,538	6,383,985
ARNP/FQHCs/RHCs	3,468,185	4,411,632	4,793,954
Rehabilitation			
▸Alcohol & Drug Treatmt FFP Only	1,146,150	1,379,831	1,553,274
▸Behavior Management FFP Only	5,063,316	10,912,658	10,912,658
▸Local Education Agencies FFP Only	661,789	1,806,792	3,033,902
▸Targeted Case Mgmt – CMRCs FFP	1,356,020	1,653,134	1,860,930
Medicare Buy–In	12,970,412	15,107,879	17,816,833
Non–Claim Adjustments	40,276	0	0
Subtotal Regular Medical	365,657,051	404,188,271	447,892,429
State Funds	166,401,745	167,747,833	184,114,385
SGF	68,823,230	80,952,952	111,569,834
Adult Care Homes			
Nursing Facilities	178,643,562	209,763,804	231,343,606
NF–MH, Cap Waivers, Other St Only	5,609,205	6,001,877	6,001,877
Intermediate Care–MR	35,910,593	35,310,593	35,310,593
Various Adjustments	1,615,633	1,615,633	1,615,633
Subtotal Adult Care Homes	221,778,993	252,691,907	274,271,709
State Funds	95,446,208	106,706,802	116,537,675
SGF	54,243,171	52,251,611	66,537,675
Community Based Care			
Elderly And Disabled	6,849,979	9,895,757	12,129,589
Mentally Retarded	18,627,351	34,092,349	39,757,849
Head Injured	541,660	846,484	1,000,000
Technology–Assisted	51,730	51,730	51,730
Subtotal Community Based Svcs	26,070,720	44,886,320	52,939,168
State Funds	10,793,464	18,184,128	21,847,011
SGF	5,865,924	18,184,128	21,847,011
Grand Total All Medical	613,506,764	701,766,498	775,103,306
State Funds	272,641,417	292,638,763	322,499,070
SGF	128,932,325	151,388,691	199,954,520

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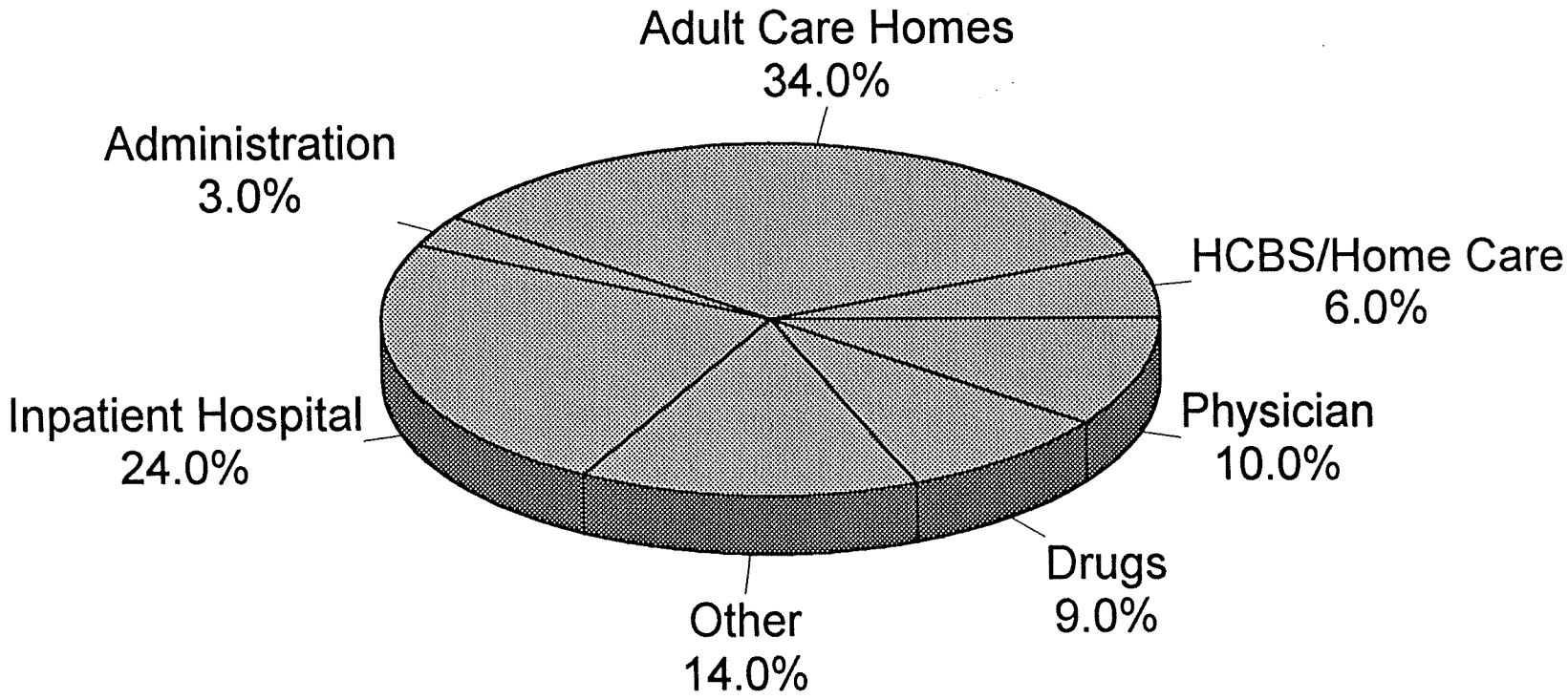
The Medicaid/MediKan Budget

How it is Spent

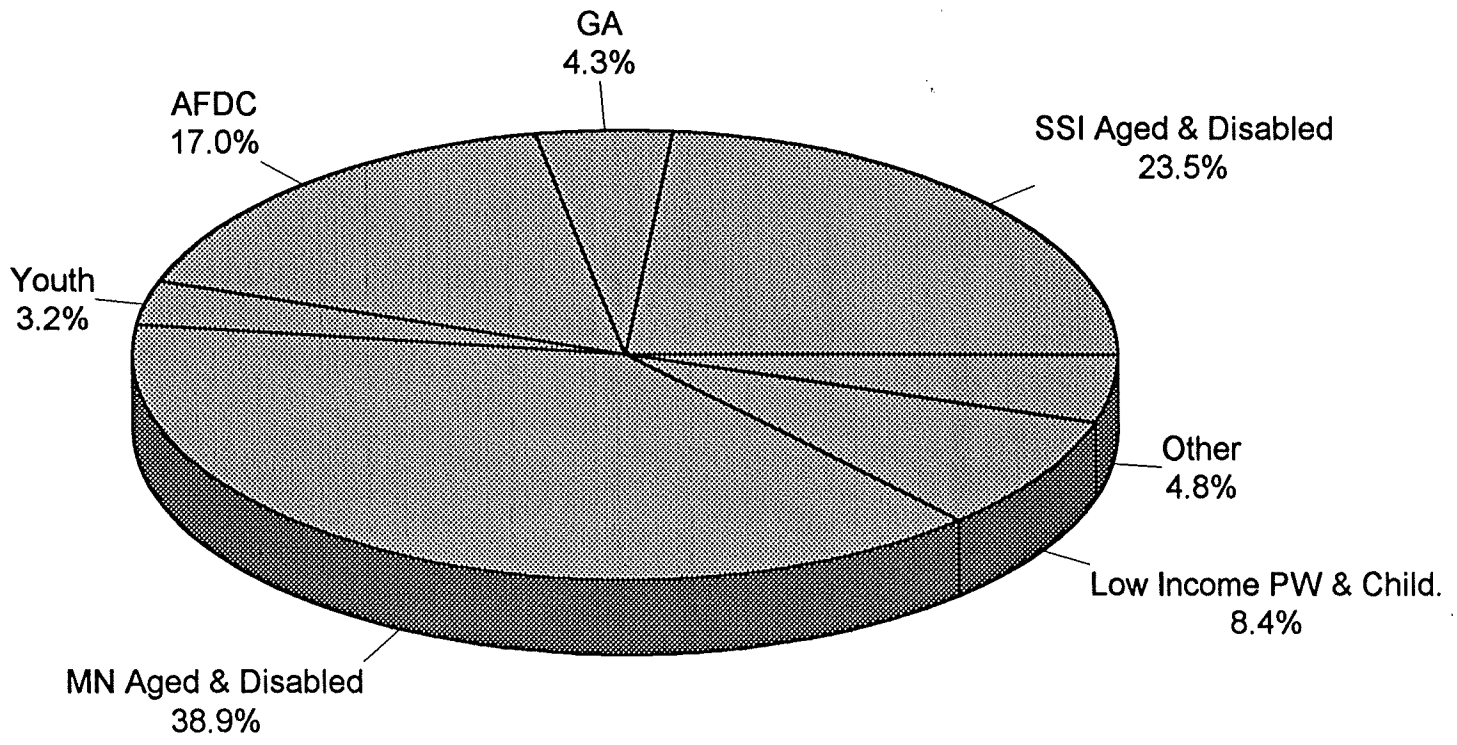


FY 1993 Actual: $647 Million.
HCBS/Home Care includes Home and Community Based Services and Income Eligible Home Care.

9-2

The Medicaid/MediKan Budget

For Whom It Is Spent



FY 1993 Actual: $613.5 Million. Excludes $33.5 million administrative Costs.
"Other" includes AFDC-Extended, QMB Buy-In, Medically Needy Families, Other.

MANAGED CARE TASK FORCE

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KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Donna L. Whiteman, Secretary

KANSAS MANAGED CARE PRELIMINARY PLAN
Update

June 24, 1993

Introduction

The Kansas Medical program is being severely strained by the continuing rise in the size of its population and cost. Managed care is considered a possible way of getting better access and quality for the funds available.

Subcommittee 2 of the House Appropriations Committee requested a preliminary plan to implement pilot managed care projects in three areas of the state. Similarly, SB 119 directs a demonstration pilot project to furnish Medicaid services through a system of managed care in Sedgwick County and one other county of the state.

This preliminary plan is in response to both of these directives.

The Kansas State Medicaid program must be reformed in order to ensure its long-term viability and to protect the state's ability to finance health care services for its aged, disabled and poor citizens. Currently costs for the program are rising rapidly. Between 1990 and 1992 program costs rose 29%. Between 1992 and 1993 program costs will rise another 17%, bringing expenditures to over $637 million. This increase is the result of larger numbers of individuals being covered under the program as well as general inflation in the costs per eligible person. The growth in the number of recipients receiving services funded by Medicaid was 11% between 1991 and 1992. Many factors contributed to increases in the number of program eligibles including expanded federal eligibility mandates and a recessionary economy. If these trends were to continue unchecked, the Medicaid program will consume an ever increasing proportion of the state's budget. By the end of the decade program costs would likely reach $2.2 billion.

A large portion of the increase in costs of Medicaid is directly or indirectly related to the inefficient nature of the program's health care delivery system. The pattern of haphazard and inefficient use of the health care system by Medicaid patients has a number of root causes that include inadequate transportation, inflexible work schedules, a lack of primary and preventive care and a tendency to postpone treatment until medical conditions have reached a crisis stage. The existing fee-for-service system is burdensome to providers and therefore some independent practitioners refuse to participate entirely or severely restrict the amount of business they do with the state. As a result, recipients must seek care from a limited range of providers, increasing waiting times for appointments and potentially discouraging individuals from obtaining preventive health care services or early intervention for a developing condition.

There is no universal definition of managed care, but there is consensus that it entails a coordinated approach to delivering and monitoring services to ensure an efficient, appropriate level of care. One characteristic all managed care plans share is an integrated system of benefits, providers, members and financial accountability. A key attribute of managed care plans is that they combine preventive, emergency and acute care services under the same administration so that children and their families benefit from a one-stop delivery system and common oversight.

There are five primary components of managed care:

- A public-private partnership exists under a contractual relationship between the payer and the provider.

- A single organization manages financial risk, membership services, fiscal accountability, and network performance.

- A network of providers is organized to deliver services to an enrolled membership.

- Reliance on a primary care "gatekeeper" physician exists to coordinate each individual's health care needs.

- Negotiated payment terms and conditions with providers are established in advance of services being delivered.

HCFA research evaluators have found managed care initiatives successful in both containing costs and in increasing service quality. In terms of cost containment, the evaluators found lower hospital utilization and emergency room usage, and lower service unit cost increases over time as compared with Medicaid fee-for-service programs. In terms of service quality, managed care programs rendered care similar to, or better than, fee-for-service programs, particularly with regard to child wellness and prenatal care services.

Not all managed care initiatives have met with success. Several Medicaid health plans have failed during the past three decades (in Arizona, Florida, California and Illinois). The owner-management of these health plans failed to perform responsively and the government regulators failed to provide adequate oversight. There are several important lessons learned from these setbacks. Among these key lessons are:

- **sufficient start-up time of approximately two years to plan and develop the organization, operations and systems is critical, especially if the government infrastructure and the provider organizations are not very sophisticated in serving Medicaid recipients in managed care models;**

- **state agencies must work with the provider communities in a partnership to develop and implement the program to ensure their participation;**

- **state agencies must employ staff skilled in managed care to oversee health plan performance on a continuous basis and address problems immediately with decisive corrective actions;**

- **state agencies must develop pre-bidder qualifications to ensure that a successful bidder organization possesses the management capabilities, provider network capacity, and financial reserves to accept the risk and responsibilities delineated in the contract;**

- **state reimbursement schemes must be actuarially sound and financial risk should not be placed entirely on the provider organization; and,**

- **a strong quality assurance program must be in place at the state and with the health plans to establish medical performance standards and to monitor medical practices before the program becomes operational.**

A June 29, 1992, United States General Accounting office testimony had the following conclusions:

> Managed care programs can offer an opportunity to improve access to quality health care. Because of the financial incentives in such programs and the vulnerability of the Medicaid population, we believe a set of safeguards must be instituted to assure adequate protection for clients. In addition to requirements to ensure quality, we believe that HCFA should require states to have in place adequate financial safeguards and oversight as we have recommended for Oregon. Further, to reduce financial risks, we have additional recommendations for the states.
>
> -- The states need to monitor the financial arrangements between the contracting plans and individual providers for incentives that could induce providers to inappropriately reduce services.
>
> -- The states also need to monitor subcontractors that assume financial risk in the same manner as contractors because the same problems can arise.
>
> -- States should require plans to routinely disclose ownership and control information.
>
> -- Finally, states should use utilization data to determine if the appropriate amount of services are being provided.

Organizational Changes

A major, systematic change is required to convert a basic, fee-for-service system to a managed care, model. It is **not** business as usual. A Medicaid managed care agency does not see its role as controlling detailed processes and regulating every provider action. Instead, it is an insurer and manager of a health care system developing risk sharing partnerships with provider groups and organizations.

The core business operations will change from one of reimbursing a medical provider for delivering discreet recipient services to contracting with a health care organization to provide a managed care delivery system to a defined

recipient population for a prospective, fixed dollar amount. Contracting will be the primary medium for communicating service delivery standards and administrative business requirements with the provider organizations.

Management will work aggressively with health care provider groups and service organizations to identify and develop competitive markets for serving Medicaid recipients. The organization will, therefore, undergo a dramatic change from a transaction processing operation to an innovative and mature public-private partnership based on competitively bid, risk management contracts.

The Division of Medical Services will have to maintain and operate existing services and programs while preparing for several substantive changes in its core business operations, for example:

- providing eligible recipients with a list of providers to choose from when medical needs arise and offering the recipients, soon after eligibility determination, an enrollment choice among available health plans,

- recruiting (and maintaining) different provider types to serve recipients and ensuring that the contracting health plans develop and maintain an adequate provider network.

- processing individual provider claims by recipient and procedures for payment and issuing a monthly prospective amount to contracting health plans to care for all enrolled members.

- supervising the provision of prior authorization and utilization review activities and having the contracting health plans perform those critical functions.

- evaluating providers for service over-utilization and working with the health plans to monitor for under-utilization.

- determining what is an appropriate fee to pay a provider for each procedure and developing a managed care risk contract with private sector organizations.

- monitoring quality of care by provider and monitoring quality of care by health plan provider networks with the health plans also being responsible for doing internal quality assurance studies.

These substantive additions will require corresponding additions to the organizational structure to support the new and expanded functions. New functions include health plan assistance and oversight, rate development, encounter data validation and processing, and member enrollment. Expanded functions include health plan contracting and management information reporting to capture capitation, member months, and utilization information. Health plan development and monitoring becomes a major organizational division responsible for technical assistance in and compliance review of financial risk management and operational performance. Rate analysis and development for capitation and reinsurance becomes a separate, and critical, program budget unit. There will

be major enhancements in the automation system to support the fiscal and utilization analytical requirements.

The Medicaid agency requires a mix of managed care experienced professionals and government service administrators to make this new model work effectively. The agency must employ the business contractual perspective from managed care professionals and the administrative compliance perspective from government service administrators. Executive managers must know how to work with the different provider communities and have extensive experience operating managed care, capitation programs. Key technical personnel must be experienced in preparing and negotiating at risk contracts (which focuses liability on the contractor rather than the State), managing quality assurance and utilization review, and developing capitation rates.

Specifically the Medicaid agency must employ the following type of personnel:

- health plan operations specialist to evaluate contractors,
- health plan financial specialist to analyze fiscal data,
- capitation rate analyst to coordinate rate development,
- quality assurance manager for utilization profiling, and
- risk management contractor for development and execution.

Process

SB 119 directs the Secretary of SRS to appoint a task force to advise the Secretary on matters relating to the pilot project and to report to the Joint Committee on Health Care Decisions for the 1990s by the beginning of the 1994 session. Members of the task force should include advocacy groups, provider organizations, managed care associates, and Medicaid and eligibility staff. The purpose of the task force is to begin building a network for a successful managed care program and to address the following key questions:

What are the managed models which other states have implemented and how feasible is it that they could be employed successfully in Kansas?

Which program models are most compatible with the environment in Kansas and the state's objectives for the program?

Which population groups should be included in the program and when?

How will the program affect access and quality of care?

What is reasonable implementation timeline?

What are the costs and resources associated with program start-up?

What level of savings (short and long term) are reasonable to expect?

How receptive is Kansas' provider community likely to be?

How can provider participation be encouraged?

Other states have hired outside consulting firms to assist them in this process and to develop a detailed implementation plan.

Successful implementation of the pilot program depends on recruiting and retaining key individuals with expertise in managed care operations and financing.

The success of a pilot managed health care program in Kansas will depend to a great extent on the quality management systems and requirements put in place.

HCFA sees four components of a comprehensive quality improvement system:

- **Active State Regulatory Oversight, Leadership and Monitoring**

- **Internal Health Plan Quality Management Programs** that are developed consistent with specific standards addressing quality management committees, clinical monitoring, credentialling, grievances, member rights, utilization management, etc.

- **Clinical and Health Services Delivery Indicators** which are carefully selected and monitored. Both clinical and nonclinical (gatekeeping functions) aspects of care must be monitored. These indicators and associated performance standards should reflect the nature of the Title XIX population thus focusing in particular, on maternal and child health. Indicators of patient outcomes must be included. Ultimately, this activity leads to the development of practice guidelines.

- **External, Independent Review** which carefully examines the quality of clinical and nonclinical aspects of care at the Health Plan annually.

The size of the community and the resources within that community will affect the approach and model of managed care programs and implemented.

All research indicates that for successful Medicaid managed care programs considerable time must be given to the design and development. Efforts to implement a program hurriedly are likely to meet with longer-term problems and/or financial failure. It is not fully known at this time the resources, system changes, and the related costs to implement the pilot projects.
The attached chart depicts a tentative timeline for implementing 1-3 pilot managed care programs.

PUBLIC POLICY GOALS:

To increase access, assure quality medical services and contain Medicaid expenditures for persons eligible for Medicaid.

OUTCOMES AND OBJECTIVES:

1. Pilot one or more models of managed care in 1-3 communities to determine if and how managed care can increase access and contain medical expenditures while providing quality medical services.

2. Increase primary care providers available to Medicaid recipients.

3. Identify varied means for reimbursing and managing medical care for Medicaid recipients.

4. Increase rate of childhood immunizations at age 2 to 6 months.

5. Reduce the percentage of low birthweight babies (from current 6.1%).

6. Reduce average number of in-hospital days (from current 7.9 days).

STRATEGY TO REACH GOALS

1. Initiate SRS Managed Care Task Force to address key issues in designing and implementing successful Medicaid managed care program.

2. Identify providers/organizations interested in pursuing/providing managed care program and build network and managed care approach.

3. Strengthen existing PCN program including integrating with hospital costs, reviewing incentives.

4. Establish data base and outcome reports and measurements.

5. Assure adequate resources are dedicated to the project. Up-front investment will be paid back in two to three years in contained growth and reduced expenditures.

There are a multitude of tasks that must be undertaken to implement managed care programs. The process starts with preparing federal waivers and recruiting personnel, and ends with implementing the program and enrolling member-recipients in contracting health plans and PCCMs.

I. Waivers

The HCFA officials have the authority to grant states waivers from existing Medicaid requirements so that they can adopt a managed care model. Kansas will need HCFA to approve several waivers that are essential to the model. HCFA will not approve waivers until it sees detailed program and financial information to support each waiver request. The key waivers the state will likely request are:

1. Limiting recipient freedom of choice to the health plans,

2. Locking in recipient enrollment to the selected health plan,

3. Guaranteeing initial enrollment for a minimum period,

4. Phasing in the recipient populations and program services,

5. Changing provider reimbursement to capitation and stop-loss,

6. Enabling non-federal qualified health care organizations to participate in the program.

A substantial amount of work is required to prepare these waivers and to negotiate them with federal officials. It is a time-consuming process and should be monitored closely.

II. Request for Proposal

Developing the data base and preparing the health plan request for proposals (RFP) are critical tasks on the workplan, as they form the basis of the rates and contract requirements. It will require extensive analytical work and communications with the provider community to develop rates and issue an RFP. Data spreadsheets on eligibility characteristics, utilization patterns, and service expenditures should be readily available to those provider groups who are interested in bidding. The project team should develop a written protocol to receive provider inquiries and respond to them quickly. The criteria for selecting successful bidders must be clearly presented in the RFP, and should include quality assurance plans, management capabilities, financial viability, and bid rates. It is certainly in the state's interest to encourage the provider community to bid. Therefore, the state must ensure that its most talented project staff lead this assignment.

III. Computer Systems

Computer systems development is another highly technical and significant task area. All of the managed care program policies and requirements will have to be clearly delineated before the systems design work can be completed. The state's MMIS will become more sophisticated as it builds new subsystems for member-recipient enrollment, health plan contracting and monitoring, capitation and reinsurance payment processing, and service utilization and management reporting. There are major system changes from the basic fee-for-service operation.

IV. Program Development and Training

The technical systems staff cannot, however, accomplish all these tasks on their own. The program staff must be involved from the beginning to define the detailed policy requirements and then to test the computer programs for acceptance. There must be training material and hands-on training of staff with regard to how to access and operate the new system. Additionally, the program and system staff must coordinate with and train the provider groups and organizations who must use or receive information from the new system. Again, this is a major, labor-intensive effort which must be well-managed from the start.

V. Enrollment

Enrollment of member-recipients into health plans is a new activity that also will require a significant amount of time to setup and administer. There are a number of policies that will need to be established pertaining to freedom-of-choice options, assignment for those members who fail to choose, and re-enrollment because of a break in eligibility. Both the members and the health plans will want a policy for disenrollment when either party is dissatisfied with the performance of the other. These are important enrollment issues from a quality of care perspective.

In addition to defining policies, the project staff must prepare member information on enrollment and make eligibility staff available to enroll members. The enrollment function will also need to offer outreach to members who are incapacitated but want to exercise their prerogative to choose a health plan. Frontline staff in the Area Office to assist in enrollment and education may be required.

The goal of the state is simple to identify, but difficult to reach: contain cost while providing good quality care. It will take strong leadership by state policymakers, qualified staff who are capable of, and committed to making it work, and providers and other stakeholders who are willing to cooperate with and participate in the initiative. If the goal is met, then everyone concerned wins, especially those children, families, and the elderly who are served by the program.

It is estimated that to implement the pilot managed care program will cost $2 to $3 million and approximately 2.5 staff for every 1000 recipients enrolled. This is a long-term investment proposal that will produce on-going dividends in terms of cost-efficiencies and stretching existing dollars to maintain service coverage.

TIME-LINE FOR IMPLEMENTATION OF KANSAS MEDICAID MANAGED CARE PLAN

Design and development activities will take two years to complete assuming everyone involved works hard and in concert. The two-year time-line is to assure that the program is initiated in order to avoid long-term problems and/or financial failure of the program. The process starts with preparing federal waivers and recruiting personnel, and ends with implementing the program and enrolling member-recipients in the managed care program. (See Attachment I.)

Key Tasks & Time Frames

Task 1: Recruitment of key managers - - - - - 3 months time frame

Subtasks:
- 1.1 Develop staff job descriptions and advertising (Outreach)
- 1.2 Evaluate/interview
- 1.3 Hire start-up staff

Task 2: Establish Task Force - - - - - 3 months time frame

Subtasks:
- 2.1 Recruit participants
- 2.2 Develop key questions
- 2.3 Establish parameters for managed care
- 2.4 Determine model public/private combination
- 2.5 Identify successful communities
- 2.6 Establish local community task groups

Task 3: Waiver development and submittal - - - - - 1 month time frame

Subtasks:
- 3.1 Organize proposal including data and objectives
- 3.2 Discussing and negotiating with HCFA
- 3.3 Revise and finalize waiver proposal

Task 4: Outsourcing Contracts - - - - - 3 months time frame

Subtasks:
- 4.1 Prepare RFP
- 4.2 Evaluate bids
- 4.3 Negotiate/award contracts

Task 5: Readiness for provider field work and data collection - - 6 months time frame

Subtasks:
- 5.1 Develop job descriptions and advertise for implementation staff (Outreach)
- 5.2 Interview and hire staff
- 5.3 Develop data requirements and collect statistics

Task 6: Provider market development - - - - - 2 months time frame

Subtasks:
- 6.1 Determine provider interest and issues
- 6.2 Analyze provider capacity and network options
- 6.3 Document existing practice and referral patterns to define market
- 6.4 Prepare business plan
- 6.5 Determine management decisions and approach

Task 7: Prepare health plan RFPs and provide technical assistance - - - - 6 months time frame

Subtasks:
- 7.1 Identify data requirements, program policies and financial risk
- 7.2 Establish bidder evaluation criteria
- 7.3 Develop bidder submittal forms and format
- 7.4 Disseminate RFP and utilization data
- 7.5 Hold bidder's conferences, answer questions, provide technical assistance
- 7.6 Actuaries develop capitation bid ranges
- 7.7 Establish committee process and structure to evaluate bids
- 7.8 Evaluate bids and make awards
- 7.9 Prepare contract with terms and conditions

Task 8: Establish PCCM participation requirement - - - - 1 month time frame

Subtasks:
- 8.1 Establish terms and conditions to participate
- 8.2 Establish panel size (minimum and maximize)

8.3 Develop application and documentation requirements
8.4 Establish partial rates and design risk pools
8.5 Enroll primary care providers
8.6 Execute contracts

Task 9: Systems design and development - - - - - 12 months time frame

Subtasks:
9.1 Complete requirements analysis - including user requirements for operation and management reports and system definition
9.2 Develop systems modification plan for hardware, software and processing
9.3 Build detailed modifications of programs, edits and controls
9.4 Test the system with user acceptance
9.5 Convert and implement systems

Task 10: Prepare and promulgate rules and policy manual - - - - - 3 months time frame

Subtasks:
10.1 Prepare draft rules and policy/procedures outline
10.2 Receive feedback and update draft rules
10.3 Arrange public hearings and comment period
10.4 Revise rules and develop policy and procedure manual
10.5 Submit rules to the Attorney General office
10.6 Finalize rules with Secretary of State

Conclusion

It is a monumental undertaking to transform a Medicaid fee-for-service operation into a managed care, capitation model. A state cannot retrofit a managed care system onto the existing fee-for-service structure with only minor modifications. Minor modifications fail to provide the member service, fiscal management and contract monitoring capabilities required of a government sponsored model.

Start-up resources and talented project management will be required to build the organization and systems needed to ensure successful transition. The state must appropriate the start up funds for managed care personnel and technical contracts for policy development, provider contracting, automation enhancements and actuarial work. Concurrently, the state cannot afford to downsize the existing fee-for-service operation until the managed care model is in place and fully operational. This is a long term investment proposal that will produce ongoing dividends in terms of cost-efficiencies and stretching existing dollars to maintain service coverage of pregnant women, children, and the elderly and disabled.

It will not be easy for the state to find talented managed care personnel and technical contractors to build the model. These people are in great demand. First, most of them are already employed working for a health plan organization or managing a large development project. Second, other state and local governments, and private health care organizations are also actively trying to

recruit them for their managed care programs. The state must be aggressive and creative to find capable manage care executives and technicians.

The state cannot afford to hire project staff who lack the skills and experience necessary to carry out the assignment. Otherwise, state expectations will not be met with respect to timely implementation, quality of care, and cost containment. Strong managed care personnel must be ready to start when the project is targeted to start.

Another challenge for the state is to prepare for the additional cash flow requirement needed to pay capitation on a prospective basis (an estimated $60 million if the entire state was participating). While the state will continue to pay fee-for-service claims (for services already rendered), it must concurrently begin paying managed care health plans upfront to cover future costs (risks). Therefore, the state will experience a spike in cash outflow. After the program starts or when a new population is phased-in. From an accrual budget perspective, the state is not paying more but instead, paying upfront for services rendered and reducing the claims tail of outstanding service bills.

The most significant outside groups that the state and its project team must collaborate with during the development process are the provider groups and organizations. The state will be asking these providers to manage recipient care and share financial risk. Before the providers will commit to participate, they will want the state to demonstrate its commitment to pay a reasonable capitation rate, to share in the risk management through stop-loss insurance and to be a responsive business partner promoting a win-win proposition. This commitment requires skillful work and a give-and-take approach. Provider groups and organizations will look to the state for technical assistance and utilization information. If their requests are met with inaction or significant delays they will be reticent to continue with the effort. This model will only succeed with the cooperation and involvement of the provider community.

The state will also be required to ensure the federal government that its capitation rates are actuarially sound and comply with the federal government mandate that the rates do not exceed the existing fee-for-service expenditures in the aggregate.

The state must also keep the recipients and their families informed about what is being developed and the rationale behind it. There is no group more affected by the anticipated changes than the recipients and their families. They should be given opportunities for input and feedback regarding policies and program development. Like the providers, it is in the state's interest to involve and work with the recipients throughout the development and implementation stages.

Based upon the state of Oklahoma's preliminary staffing needs to start up an Office of Managed Care for the Oklahoma's Medicaid program, the following is a preliminary outline of the duties and responsibilities of key staff members initially needed for a Kansas pilot Managed Care Program. This is with the assumption there would be extensive consulting services provided:

Team Leader, Managed Care
Responsibilities: Strategy and policy development
Waiver negotiation
Program monitoring and direction
Public Interface

Social Service Administrator IV

Chief Rate Analyst
Responsibilities: Encounter data validation
Capitation rate setting
Fee for service equivalency monitoring
Utilization projections

Management Analyst IV

Contract Manager
Responsibilities: Plan/provider contracting, auditing, and reporting
Plan compliance and performance monitoring
FFS network interface
Contract terms

Social Service Administrator III

Quality Assurance/Utilization Review Manager
Responsibilities: Total quality management
Case management services
Utilization review standards
Quality assurance program operations

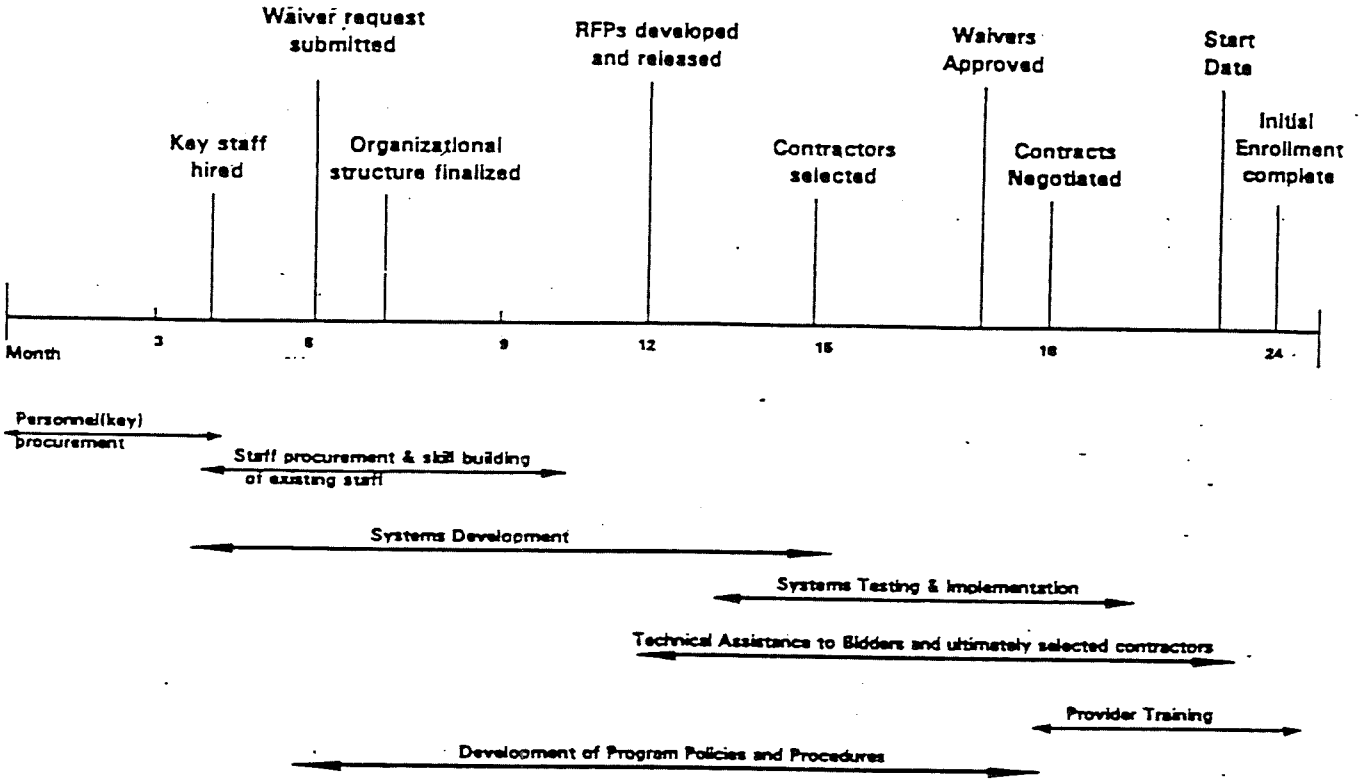
Social Service Administrator III
Field Coordinator
Responsibilities: Recipient and provider education
Coordinate with Staff Development development of training

Social Service Administrator II

Administrative Support
Secretary II
Two (2) Office Assistant III

Note: Once a more detailed plan is developed, additional staff/contracts may be needed.

TIME-LINE FOR IMPLEMENTATION OF KANSAS MEDICAID MANAGED CARE PLAN



Because all children need someone who cares . . .
Kansas Action for Children, inc.
A non-profit, tax-exempt organization.

715 SW 10th
P.O. Box 463
Topeka, Kansas 66601
(913) 232-0550
Johannah Bryant
Executive Director

January 28, 1992

TESTIMONY ON HOUSE BILL NO. 2695
TO HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE

By Pat Schloesser, M.D., KAC Medical Advisor

Bulletin Nos. 8 and 9, August-Sept. 1918
Kansas Board of Health

"PHYSICAL INSPECTION OF SCHOOL CHILDREN
Before starting on a long journey the careful automobilist makes certain that the machine is in perfect condition for the trip. Even starting with a perfect machine, a long trip is likely to bring out or develop unsuspected defects. Just as logical as the careful inspection and repair of an automobile preparatory to a trip is the examination and treatment of the defects of a child before starting to school each year. A parent or guardian of a school child needs to be certain that the child can see well, that he hears well, that his teeth are good, and that he is free from defects which will interfere with his health and school progress."

POSITION STATEMENT: Kansas Action for Children supports this bill which will establish a state health policy to assure that all Kansas children receive a health check-up upon school entrance. We recognize that entering school is an important checkpoint in each child's life, and that children with undetected health problems experience greater difficulties in their schooling than healthy children. A state law is now needed to close the gap of approximately 20-25% of children who do not receive this basic health service. The bill provides for certain exemptions, allows time for compliance, and provides a health resource through local health departments, in situations when private medical resources do not meet the need.

FACTUAL BACKGROUND

* For seventy-five years, Kansas schools and public health authorities have promoted health check-ups for school enterers on a voluntary basis, through provision of health forms, pre-school round-ups and health education efforts, which now reach 75-80%.

* Since 1951, all children entering licensed child care facilities have been required by KDHE regulations to present a health assessment form.

2-24

* National organizations and their state counterparts back the requirement for a preschool health appraisal. These include the American Academy of Pediatrics, American Public Health Association, the National Parent-Teachers Association, American School Health Association, and advocacy groups such as the Children's Defense Fund and the Congressional Select Panel on Children and Families.

* National studies of the Headstart Program which couples preschool education with health services, reveal that these children progress better in school, and for each $1 invested, $4.75 is saved in health and educational costs.

* State studies in the late 1970's at Kansas Youth Facilities found that 50% of these children had significant undetected health problems during their earlier school years.

* Only 14.5% of Medicaid eligible children receive a health assessment under the voluntary "Can Be Healthy" (EPS) program. This law would assure 100% for clients entering school. It might also identify other families who are medicaid eligible.

* A school health survey conducted by KDHE in the mid-80's found that 33% of school districts had a local requirement, and more than half of Kansas children resided in these districts.

* The existing law requiring immunizations, has resulted in over 96% compliance - a similar rate for health assessments could be expected.

ADDITIONAL RECOMMENDATIONS

1. Deletion of the words "or personal" on line 23, p.2, as it is no longer relevant. The original 1961 immunization law provided for a "personal belief" exemption under KSA 72-5209 which was eliminated by the legislature in the 1970's.

2. A companion law KSA 72-5211a provides for suspension of pupils from school for non-compliance with the original KSA 72-5209 relating to certification of immunizations. The lack of immunizations by some segments could result in the spread of communicable disease and in this situation, exclusion is appropriate. Not so, for health assessments which are designed to benefit the individual child. Therefore, we recommend amendment of KSA 72-5211a to limit the suspension to (a) 1, of KSA 72-5209.

3. Finally please note the content of health assessments in the two attached appendices.

2-25

Marlin L. Rein
University of Kansas Medical Center
Senate Public Health and Welfare Committee
January 26, 1994

I would like first to express my appreciation to the committee for arranging this meeting. As you can tell by the attendance today, there is a great deal of interest in this issue and the manner in which the Legislature directed the Secretary of the SRS to establish a Medicaid managed care pilot at the University of Kansas Medical Center. I will be brief in my remarks focusing on three areas of concern.

The first issue I would address are the questions that have been raised relative to the manner in which the Legislature directed SRS to implement this pilot. Senate Bill 119 specifically addressed two other counties with no mention of the Medical Center. The Legislature's direction to the Secretary to develop a pilot at the Medical Center occurred during legislative consideration of the SRS budget. As a state institution, we saw nothing unusual about this as we often receive policy directions from the Legislature through the appropriations process. Further, while we did not seek this initiative, it is, again, not unusual for the Legislature to provide directives on matters not initiated by the institution.

The second issue relates to the impact such a pilot might have on other healthcare providers in Wyandotte County. Since the session there has been little information forthcoming about the manner in which SRS intended that this pilot be implemented. As a result there has been much speculation concerning the potential harm such a program could inflict on other healthcare providers. I have, in fact, heard it said on several occasions that all Medicaid patients in Wyandotte County would have to be served at the Medical Center. I strongly disagree with that and I would note that the directive in the SRS Subcommittee report does not even mention Wyandotte County, much less infer that all Medicaid services would be provided at the Medical Center. We have never presumed that the Legislature was attempting to direct more patients to us at the expense of other providers.

I would further point out that the institution is already a major provider of services to Medicaid clients. In Fiscal Year 1993, 25 percent of our Hospital discharges were Medicaid patients. As a state university hospital, we should be a major provider to Medicaid patients and we will continue to do so. However, it is not an objective of ours to increase this panel of patients through the mechanism of a managed care pilot program.

Thirdly, let me say that the University of Kansas Medical Center is a member of the healthcare provider community in Wyandotte County. We do not want to harm that network of healthcare providers or lessen the quality or quantity of services available to

Senate PH&W
attachment #3
1-26-94

Medicaid clients. However, as long as there is an expectation by the Legislature that we institute such a pilot, we have no choice but to attempt to comply. In reality, if managed care is to come to this area, it will probably have to include other providers in addition to the Medical Center. At the moment, no vehicle exists to make this happen. Perhaps creation of a local planning group made up of a balanced membership of the various providers in the community would be an appropriate first step.

I think this hearing today will be most beneficial if the Legislature could affirm two points that I have made: 1.) The institution did not seek this authority to initiate a pilot but was willing to undertake it at the Legislature's direction; and 2.) It was never the Legislature's intent that all or even an increased number of Medicaid patients be directed to the Medical Center as a result of this pilot project. In my opinion, clarification of these two points would eliminate much of the concern others have regarding this issue.

Thank you. I will be happy to stand for questions.

Re: Hearing on HB 2047 and Sub SB 437
State House
January 26, 1994

Introduction

Dannie M. Thompson M.D.
Private Practice OB-Gyn KC, KS since 1968
Consultant Wyandotte Co. Health Dept since 1968
Member Kansas Medical Society - SRS Advisory Committee
Member Managed Care Task Force for State of Kansas
Staff member Providence and Bethany Medical Centers
Co-Chair - Managed Care Advisory Committee in Wyandotte County
Member of ACOG Task Force on Health Care Reform to Clinton Adm.
OB-Gyn Consultant - Kansas Health and Environment - FP\PN Dept.

I would personally like to thank Senators Praeger and Jones for their efforts in arranging this hearing addressing the parts of HB 2047 and Sub SB 437 which authorized a third pilot care project at the University of Kansas Medical Center in addition to the two pilot projects for managed care mandated by SB 119.

In spite of all of the confusion about this project, it is truly a community issue on how poor people will get health care and who will manage it.

I want to talk to you about how health care for the poor has been provided in Wyandotte County by referring to a pet project of mine which which began in 1968, which has become the pride of my life. The contents of that project are outlined in a paper I presented in 1975 of which you have a copy. Over the years, the statistical parts of that paper have been updated but the contents have remained the same. The paper had been presented many times since 1975, locally, regionally, and nationally. The most recent presentation to members of the ACOG Task Force on Health Care Reform as it consulted with the Clinton Administration.

The project was devised to assure that prenatal care would be available to all KC, KS - Wyandotte County residents, irregardless of ability to pay.

The primary elements of the program consists of:

Access
Quality
Choice
Removal of barriers - economic, social-racial
Provider Identity
Continuity of Care
Respect, Compassion, and Dignity

Senate PH&W
attachment # 4
1-26-94

This program has grown from a total of 50 deliveries a year to more than 500 deliveries per year. In the years 1970-1975, the clinic population was 36% Medicaid and 64% non-Medicaid (No Pay). In 1993, there were 65% Medicaid and 35% non-Medicaid.

In addition to the clinic patients, our practice delivers about 500 patients per year of which about 75% are Medicaid patients.

It is very important to note that throughout the years, other providers, hospitals (Providence and Bethany), doctors, laboratories, pharmacies, social services, as well as the political structure of our community have been equal partners in this effort.

When the question arises as to who I represent in this matter. Primarily, I represent many of the 30,000 Medicaid or eligible patients in the community. Secondly, I represent the providers who have historically provided services to those patients in the community.

Any health care plan, be it managed or traditionally, should be primarily directed to take care of the health care needs of the patients and to assure access, quality, and choice for its patient population.

Managed Care Projects

It is interesting that there has been a Managed Care Project in KC, KS - Wyandotte County since 1985, called the Primary Care Network (PCN) project which utilized the 'Gate Keeper' concept of Managed Care in which each patient would choose from a list of provider doctors. This list included both doctors from the community and from Kansas University Medical Center.

I would like to summarize a report dated July 27, 1993 about that program.

Summary PCN Program

Providers:	KUMC	=	36	or 41%
	Community	=	51	or 59%
	Total	=	87	
Patients:	KUMC	=	4,255	or 24%
	Community	=	13,120	or 76%
	Total	=	17,375	

Patients at KU by Department

Peds	=	2,550	or 60%
OB\Gyn	=	693	or 16%
FP	=	753	or 17%
IM	=	309	or 7%

What is the significance of the passage of HB 2047 and Sub SB 437 which authorized KUMC to have a Managed Care Project.

The Project:

* Which was decided in a committee,
* Composed of a small number of legislators and a few others,
* Of which there was no established need, reason, or direction for the project,
* Passed upon in committees,
* Confirmed in the Veto Session of the legislature without knowledge or input, from patients, providers, or even legislators affected by its passage.

The project has said to the "Patients of our Community," that your access to care and choice of provider is not important and that someone in Topeka has decided who can manage your care best.

The project says to the "Providers of our Community," that we ignore the fact that you have historically provided care for those patients, but no longer qualify or are capable of providing for their care.

How can this be rectified?

This can only be rectified by the legislature taking appropriate political action to immediately delete this project as part of HB 2047 and Sub SB 427.

What about the future?

If a pilot project is needed in our community, present it as a project, subject it to the same political process and scrutiny as the projects in SB 119, after such action we will be happy to do our parts in its implementation.

Thanks,
Respectfully Submitted,

Dannie M. Thompson M.D.

A Clinical Obstetrical Service with Private Care Orientation.

Introduction:

In July when I was asked to present a paper for this meeting and agreed to do so, I began to ponder in my mind a subject or presentation that would be of interest to this group. I had just operated on an eighty five year old lady with a large abdominal mass and received the pathology report, which reported "Invasive Squamous Cell Carcinoma in a Dermoid Cyst". I immediately said this is the topic I would present. After second thoughts, I concluded that I could relate this topic to any one of this learned group and within thirty minutes any person could search the appropriate literature and obtain adequate knowledge afore mentioned entity.

I likewise considered that most of the papers presented in our meetings are scientific, medically oriented papers, therefore, I elected to relate an experience which extended beyond the purely medical aspect of practice but endeavors upon the social needs of the community. Thus the topic of my paper: "A Clinic Obstetrical Service with Private Care Orientation".

This experience began in the late winter of 1968, at which time I had committed myself to private practice in Kansas City, Kansas. I was approached by the Supervisor of the Wyandotte County Health Dept. who related to me a need for Community Obstetrical Services to be provided through that facility, requesting that I outline a workable program to provide those services. I agreed to look into the matter.

One of my first considerations, with this being 1968, in the middle of the political pushes of the Great Society, are these services truly needed or are they being established because of available fundings. Therefore, I began to do some basic research in the community. The first consideration was what services are already being provided and I found that there were six actively practicing OB-GYN doctors in the community, two of whom were anticipating retirement from the practice of OB-GYN. I also found that many General Practitioners and Family Practitioners were discontinuing their OB practices. I found that beyond the private sector the patients sought Obstetrical Services at Kansas University Medical Center which is located at some distance from many of the patients needing these services.

Considering these factors I established a legitimate need for the services.

A second consideration to be made from a personal standpoint, being a new physician in the community, would the private sector, county medical society and university approve the establishment of such services, however after some thought I decided that if there existed a true need for the services it really didn't matter if they approved or not so I would take my chances and pay the price. I can happily and proudly report that opposition has been minimal.

Original Paper Presented to the Kansas City Gynecological Society — September 1975

Wm Thompson

General Philisophy:

After deciding a need for the services a philosophy for approach for establishment had to be determined. An accepted philosophy "Good Prenatal Care will Lead to Healthier Pregnancies and help reduce Perinatal and Maternal Morbidity and Mortality". Therefore, any pregnant woman has a right and responsibility to receive good prenatal care. If this philosophy is valid one must consider why some pregnancy women do not receive prenatal care. There must be obsticles or barriers to discourage these patients. These had to be eliminated or overcome.

Barriers to Prenatal Care:

1. Prenatal care not available because of the shortage of manpower.

2. Prenatal care inaccessable because of location and no good transport mechanism.

3. Inappropriate and impersonal appeal by some of the existing sytems providing prenatal care.

4. Finincial barriers which makes it unreasonale if not immpossible to receive prenatal care.

5. General neglect or disinterest of the patient herself in receiving prenatal care.

With those factors in mind together with my experience as a resident working in a system providing care to socially, economically and medically deprived patients I sought a system or plan that would in the best way possible eliminate the barriers and obsticles. Therefore good prenatal care would be available to anyone in the community desiring it.

Organization of Clinics:

Location:

As mentioned one of the obsticles to our cause as a Health Care Provider is accesibility - therefore we chose two neighborhood centers

1. Bethal Center
2. Parkwood Center

Both located in highly productive areas of the inner city and a distance removed from existing prenatal services; with a high censor of low income and young people. The Bethal Center was later removed to the locale of the Wyandotte County Health Department because of need of additional space.

Delivery of Care:

Our interpretation of delivery of prenatal care from diagnoses of pregnancy, through delivery and post partum examination with family planning instructions.

The initial encounter with the patient entails a complete history and physical examination done by the physician, along with appropriate laboratory work including CBC, UA, Type and RH, Rubella Titer and Serology. Patients are given prenatal educational materials along with dietary instructions. The patients are followed at intervals compatible to their needs and months of gestation. At this point our clinic differs from other clinic type service delivery. I recalled my experience as a resident when we delivered the patients from the Richard Cabot Clinic, Crittenton Home and patients who received prenatal care from private physicians, but delivered at General Hospital. I remembered how lost and unfamiliar the patients were with the system and the feeling they often expressed of having a doctor with whom they had no previous contact deliver them. Further the communication and transfer of records left much to be desired in providing good care. Another strong factor to be considered that is often ignored by health care delivery systems, is that delivery of health care - especially obstetrical care cannot be limited to 8.00 am to 5.00 pm Monday through Friday, It must be available twenty four hours a day, seven days a week. Therefore, I elected to avail myself and my associates to these patients on a twenty four hour basis, if problems or need for care arose on days the clinic was not available the patients would be seen in the office without any financial obligation. The patients were to be delivered by our group at the hospital of their choice where we practiced.

Every effort is made to be sure that the patients are treated with respect, compassion and dignity on each encounter, be it in the clinic, hospital or office setting. Likewise we insist that the patients receive the same level of care and services as any other patients in our practice.

After delivery the patients are followed for post partum visits and given an examination and family planning services.

Statistics From Prenatal Clinic

1970 Through 1975

Total Deliveries

=

814

These statistics are available at your request

Conclusions:

1. We have attemped to establish a health care delivery system to provide good prenatal care to a needy group of patients through the cooperation of a public agency and private physicians.

2. The majority of the patients serviced are between the ages of 15 - 25 and having less than two children.

3. We attemped to remove barriers, obsticles which usually prevent patients from receiving prenatal care and feel that we successfully did so.

4. The medical outcome of the pregnancies is considered excellent.

5. We noted a good patient acceptance of our program as evidenced by few complaints, patients' attendance, follow-up and repeat statistics.

THE MEDICAID PRIMARY CARE NETWORK PROGRAM DOES REDUCE COSTS FOR MEDICAL SERVICES AND IMPROVES THE QUALITY OF CARE

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Robert C. Harder, Secretary
Office of Analysis, Planning, and Evaluation
February, 1985

The Office of Analysis, Planning, and Evaluation is part of the Office of the Secretary, and is directed by the Executive Assistant for Policy and Program Development, Aileen C. Whitfill. The Chief Analyst of the Office is Mark Levy. The Management Analysts are Stephen Schiffelbein and Stephen Ferrier, and the Secretary is Bonnie Still.

THE PRIMARY CARE NETWORK PROGRAM

SECTION I

INTRODUCTION

The Secretary of the Department of Social and Rehabilitation Services directed the Office of Analysis, Planning, and Evaluation to study the Kansas Medicaid/MediKan Primary Care Network program (PCN). In the PCN program, all Medicaid clients have a primary care physician who provides or approves through referrals all medical care for the PCN client. PCN was implemented in February 1984 in Sedgwick, Saline, and Ottawa counties. A waiver of the federal freedom of choice regulations was required because PCN restricts clients from receiving medical care without the approval of their primary care physician, except in emergencies.

The goals of Kansas' PCN are to improve Medicaid clients' access to medical care and to contain Medicaid costs. PCN ensures every Medicaid client has a primary care physician and it prevents Medicaid clients from unnecessarily using emergency rooms or other unnecessarily costly medical services. This study of PCN was intended to answer two key questions about PCN. First, has PCN improved Medicaid clients' access to a primary care physician, and are clients satisfied with the care they are receiving? And second, has PCN reduced the costs of Medicaid services by preventing unnecessary usage of emergency room services and otherwise changing the way clients utilize medical services?

To answer these questions the analysts did several types of work. First, they reviewed statistical reports to determine the number of clients in the program, the number of primary care physicians by specialty, the costs of PCN by physician specialty, and other descriptive information about the program. Second, they reviewed letters received by SRS from physicians and clients. Third, they interviewed by phone 50 PCN physicians, 50 PCN clients, and administrators at five hospitals in the PCN counties. They also interviewed staff at the area offices involved in PCN. Finally, the analysts compared Medicaid costs and medical utilization for clients in PCN counties to clients in three comparison counties not involved in PCN. The costs and medical utilization for clients in both PCN and the non-PCN counties were examined for a six-month period prior to PCN implementation and a six-month period after implementation to determine if PCN had caused any clear shifts in costs or medical utilization.

The key findings of this study are: 1. A significant percentage of clients believe PCN increase their access to primary medical care and PCN measurably decreased Medicaid expenditures for PCN clients, primarily because of reduced utilization of emergency room and other hospital outpatient services. 2. Both client interviews and data on utilization of medical services indicate the effect of PCN is much greater in the urban PCN county. However, the data are probably too limited, and it is too early, to firmly conclude that PCN is not worthwhile in rural counties. 3. Almost all negative comments about PCN are related to the way clients were initially assigned to physicians. This study discusses specific solutions that might solve the problems in the client assignment process.

012 DEPT OF FAMILY PRACTICE-KUMC-KANSAS CITY
013 DEPT OF OBSTETRICS AND GYN.-KUMC-KANSAS CITY
014 DEPT OF INTERNAL MEDICINE-KUMC-KANSAS CITY

HMKR463H 07/27/93

ELIGIBLE PCN PROVIDERS
IN WYANDOTTE COUNTY
BY SPECIALTY & NAME

CTY	SPCD	NUMBER	NAME			GRP AFL	ADDRESS	CITY	ST	ZIP	CASELOAD COUNTS CURR	MAX	$
105	GEN PRACT	500665	BAIG	AHMED	J MD		1610 WASHINGTON BLVD	KANSAS CITY	KS	66102	139	150	
105	GEN PRACT	500188	BETTS	JOAHN	J MD		1217 NORTH FIFTH STR	KANSAS CITY	KS	66101	135	150	X
105	GEN PRACT	295086	BRADBURY	GLEN	I DO		134 N NETTLETON	BONNER SPRINGS	KS	66012	137	400	
105	GEN PRACT	296212	GAMBLE	JOHN	D DO		1509 QUINDARO	KANSAS CITY	KS	66104	1303	1552	
105	GEN PRACT	563789	GARRISON	KYLE	D DO		667 SO 55TH ST	KANSAS CITY	KS	66106	251	1200	
105	GEN PRACT	513112	GOSALIA	ANIL	V MD		1610 WASHINGTON BLV	KANSAS CITY	KS	66102	603	1500	
105	GEN PRACT	516131	HOLMES	FRED	F MD	014	SEE AFFILIATE TABLES				41	50	
105	GEN PRACT	516558	HUET-VAUGHN	YOLANDA	MD		FAMILY HEALTH SERV K	KANSAS CITY	KS	66103	101	1500	
105	GEN PRACT	501103	JEVONS	ROBERT	E MD		4601 ORVILLE	KANSAS CITY	KS	66102	59	250	
105	GEN PRACT	516066	JOHNSON	BRUCE	MD	014	SEE AFFILIATE TABLES				50	50	
105	GEN PRACT	503174	JOHNSON	CLIFFORD	D MD		120 N NETTLETON	BONNER SPRINGS	KS	66012	33	100	
105	GEN PRACT	517477	JOHNSON	CYNDA	A MD	012	SEE AFFILIATE TABLES				99	100	
105	GEN PRACT	516279	JOHNSON	DAVID	B		4601 ORVILLE	KANSAS CITY	KS	66102	387	1500	
105	GEN PRACT	503593	KING	W RUSSELL	MD		4601 ORVILLE	KANSAS CITY	KS	66102	22	300	
	GEN PRACT	503889	LARSON	MARK	W MD		3901 RAINBOW BLVD	KANSAS CITY	KS	66160	33	50	
:	GEN PRACT	2K1014	LEE	GERALD	B MD		3015 STRONG AVE	KANSAS CITY	KS	66106	298	1500	
105	GEN PRACT	519020	LEE	SHARON	D MD		506 SOUTHWEST BLVD	KANSAS CITY	KS	66103	336	1500	
105	GEN PRACT	563824	LEGLER	GARY	L DO		10620 KAW DRIVE	EDWARDSVILLE	KS	66116	70	1500	
105	GEN PRACT	503136	MEYER	MARK	C MD		39TH & RAINBOW BLVD	KANSAS CITY	KS	66160	49	50	
105	GEN PRACT	260425	MILLIGAN	DONALD	B MD	012	SEE AFFILIATE TABLES				97	100	
105	GEN PRACT	518232	MOORE	LYDIA	A MD		1401 SOUTHWEST BLVD	KANSAS CITY	KS	66103	391	1500	
105	GEN PRACT	501572	MURRAY	JANE	L MD		39TH & RAINBOW	KANSAS CITY	KS	66103	49	50	X
105	GEN PRACT	502972	NEWBERT	LEANNE	D MD		120 N NETTLETON	BONNER SPRINGS	KS	66012	31	100	
105	GEN PRACT	261213	NUNEZ	JULIAN	M MD		4631 ORVILLE S-115	KANSAS CITY	KS	66102	458	1500	
105	GEN PRACT	510390	PALMERI	MARIA	MD		4631 ORVILLE	KANSAS CITY	KS	66102	48	50	X
105	GEN PRACT	506114	PAREKH	MADHAVI	A MD		6013 LEAVENWORTH RD.	KANSAS CITY	KS	66104	103	1500	

CODE VALUES:

STATUS CODE DESCRIPTION
- A — ADULTS ONLY 14 & OLDER
- X — PRESENT PATIENTS ONLY
- BLANK — NO RESTRICTIONS

GROUP AFFILIATION DESCRIPTION
- 001 — ST. JOSEPH FAMILY PRACTICE CENTER
- 002 — UNIV. OF KANSAS SCHOOL OF FAMILY PRACTICE PHYS.-WICHITA
- 003
- 004
- 005 — UNIV. OF KANSAS SCHOOL OF MEDICINE-INTERNAL MED.-WICHITA
- 006 — SMOKY HILL FAMILY PRACTICE
- 007 — ST. FRANCIS FAMILY PRACTICE
- 008 — WESLEY MEDICAL CLC-PEDIATRICS
- 009 — WESLEY MEDICAL CLC-OB/GYN
- 010 — DEPT OF PEDIATRICS-KUMC-KANSAS CITY
- 011 — DEPT OF FAMILY PRACTICE-KUMC-KANSAS CITY
- 012 — DEPT OF OBSTETRICS AND GYN.-KUMC-KANSAS CITY
- 013 — DEPT OF INTERNAL MEDICINE-KUMC-KANSAS CITY
- 014

HMKR463H 07/27/93
ELIGIBLE PCN PROVIDERS
IN WYANDOTTE COUNTY
BY SPECIALTY & NAME

CASELOAD

007 SMOKY HILL FAMILY PRACTICE
008 ST. FRANCIS FAMILY PRACTICE
009 WESLEY MEDICAL CLC-PEDIATRICS
010 WESLEY MEDICAL CLC-OB/GYN
011 DEPT OF PEDIATRICS-KUMC-KANSAS CITY
012 DEPT OF FAMILY PRACTICE-KUMC-KANSAS CITY
013 DEPT OF OBSTETRICS AND GYN.-KUMC-KANSAS CITY
014 DEPT OF INTERNAL MEDICINE-KUMC-KANSAS CITY

HMKR463H 07/27/93

ELIGIBLE PCN PROVIDERS
IN WYANDOTTE COUNTY
BY SPECIALTY & NAME

CTY	SPCD	NUMBER	NAME			GRP AFL	ADDRESS	CITY	ST	ZIP	CASELOAD COUNTS CURR	MAX	S
105	GEN PRACT	264442	PARRA	MIQUEL	E MD		6013 LEAVENWORTH	KANSAS CITY	KS	66104	273	1500	
											93	100	
105	GEN PRACT	517478	PERRY	LAWRENCE	L MD	012	SEE AFFILIATE TABLES						
105	GEN PRACT	500734	RAMBERG	STEVE	MD		1428 S 32ND ST	KANSAS CITY	KS	66106	142	158	X
105	GEN PRACT	563704	REDMON	MARY	L DO	012	SEE AFFILIATE TABLES				95	100	
105	GEN PRACT	518081	RUBLE	REBECCA	A MD	012	SEE AFFILIATE TABLES				97	100	
105	GEN PRACT	517756	SAYEGH	JOHN	A MD		1332 S 42ND ST	KANSAS CITY	KS	66106	443	1500	
105	GEN PRACT	502900	SMITH	DAVID	M MD		3901 RAINBOW BLVD	KANSAS CITY	KS	66160	41	50	
105	GEN PRACT	501573	SMITH	MARGARET	L MD		39TH & RAINBOW	KANSAS CITY	KS	66103	97	100	
105	GEN PRACT	516733	TIOJANCO	REYNALDO	MD		6013 LEAVENWORTH RD	KANSAS CITY	KS	66104	83	1500	
105	GEN PRACT	501131	VAIL	BELINDA	MD		39TH & RAINBOW BLVD	KANSAS CITY	KS	66103	99	100	
105	OB - GYN	264510	ALEXANDER	CHARLES	E MD		4TH & STATE S-911	KANSAS CITY	KS	66101	464	1500	
105	OB - GYN	517693	BENNETT	TIMOTHY	L MD		SEE AFFILIATE TABLES				79	200	
105	OB - GYN	509894	CALKINS	JOHN	W MD	013	SEE AFFILIATE TABLES				288	1500	
105	OB - GYN	510017	CAMERON	WILLIAM	J MD	013	SEE AFFILIATE TABLES				26	50	
105	OB - GYN	503488	FARO	SEBASTIAN	MD		3901 RAINBOW BLVD	KANSAS CITY	KS	66160	38	1500	
105	OB - GYN	518297	FINLEY	BRENT	E MD	013	SEE AFFILIATE TABLES				114	1500	
105	OB - GYN	503350	HAMNER	DABNEY	J MD		1217 N 5TH ST	KANSAS CITY	KS	66101	5	50	
105	OB - GYN	510006	HARA	GLENN	S MD	013	SEE AFFILIATE TABLES				32	50	
105	OB - GYN	261371	JAHANIAN	DARYOUS	MD		8919 PARALLEL PKWY	KANSAS CITY	KS	66112	10	100	
105	OB - GYN	509995	KRANTZ	KERMIT	E MD	013	SEE AFFILIATE TABLES				65	1500	
105	OB - GYN	503363	LAMBERT	KENNETH	J MD		1217 N 5TH ST	KANSAS CITY	KS	66101	6	500	X
105	OB - GYN	516598	MILLER	DENNIS	W MD,PA		600 NEBRASKA	KANSAS CITY	KS	66101	118	1500	
105	OB - GYN	504426	QUINN	CHARLES	MD		2 GATEWAY,4TH&	KANSAS CITY	KS	66101	306	1500	
105	OB - GYN	503129	RIDGWAY	LOUIS	E MD		3901 RAINBOW BLVD	KANSAS CITY	KS	66160	11	200	
105	OB - GYN	518611	SNYDER	THOMAS	E MD		3900 RAINBOW BLVD.	KANSAS CITY	KS	66103	40	1500	
105	OB - GYN	261808	THOMPSON	DANNIE	M MD		TWO GATEWAY CENTER	KANSAS CITY	KS	66101	743	1500	

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002 UNIV. OF KANSAS SCHOOL OF FAMILY PRACTICE PHYS.-WICHITA
003
004
005 UNIV. OF KANSAS SCHOOL OF MEDICINE-INTERNAL MED.-WICHITA
006 SMOKY HILL FAMILY PRACTICE
007 ST. FRANCIS FAMILY PRACTICE
008 WESLEY MEDICAL CLC-PEDIATRICS
009 WESLEY MEDICAL CLC-OB/GYN
010 DEPT OF PEDIATRICS-KUMC-KANSAS CITY
011 DEPT OF FAMILY PRACTICE-KUMC-KANSAS CITY
012 DEPT OF OBSTETRICS AND GYN.-KUMC-KANSAS CITY
013 DEPT OF INTERNAL MEDICINE-KUMC-KANSAS CITY

HMKR463H 07/27/93
ELIGIBLE PCN PROVIDERS
IN WYANDOTTE COUNTY
BY SPECIALTY & NAME

4-11

CASELOAD COUNTS

006 UNIV. OF KANSAS SCHOOL OF MEDICINE-INTERNAL MED.-WICHITA
007 SMOKY HILL FAMILY PRACTICE
008 ST. FRANCIS FAMILY PRACTICE
009 WESLEY MEDICAL CLC-PEDIATRICS
010 WESLEY MEDICAL CLC-OB/GYN
011 DEPT OF PEDIATRICS-KUMC-KANSAS CITY
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014 DEPT OF INTERNAL MEDICINE-KUMC-KANSAS CITY

HMKR463H 07/27/93

ELIGIBLE PCN PROVIDERS
IN WYANDOTTE COUNTY
BY SPECIALTY & NAME

CTY	SPCD	NUMBER	NAME			GRP AFL	ADDRESS	CITY	ST	ZIP	CASELOAD COUNTS CURR	MAX	S
105	OB - GYN	518350	WEED	JOHN	C MD	013	SEE AFFILIATE TABLES				23	1500	
105	PEDIATRICS	501261	HEIMES	SHARON	M MD		P O BOX 27-476	KANSAS CITY	MO	64180	20	50	
105	PEDIATRICS	502138	PALAZZOLO	MICHAEL	MD		3901 RAINBOW	KANSAS CITY	KS	66160	927	1500	
105	PEDIATRICS	260482	PORTER	DAVID	M MD		4517 TROUP	KANSAS CITY	KS	66102	1472	1500	
105	PEDIATRICS	502233	RUBIN	BEN	MD JR		2401 GILLHAM ROAD	KANSAS CITY	MO	64108	144	150	
105	PEDIATRICS	263946	SCHAUM	STEPHEN	P MD		4517 TROUP	KANSAS CITY	KS	66102	1444	1500	
105	PEDIATRICS	501233	SHAW	PAMELA	K MD		3901 RAINBOW	KANSAS CITY	KS	66160	867	1500	
105	PEDIATRICS	506845	THEROU	LEONA	MD	011	SEE AFFILIATE TABLES				868	1500	
105	PEDIATRICS	518895	TICKLES	DEBRA FARME	MD		8919 PARALLEL	KANSAS CITY	KS	66112	341	500	
105	PEDIATRICS	500549	TUCKER	VIRGINIA	MD		3901 RAINBOW BLVD	KANSAS CITY	KS	66160	778	1500	
105	PEDIATRICS	500527	WILKERSON	SHARON	R MD		P O BOX 27-476	KANSAS CITY	MO	64180	23	150	
105	PEDIATRICS	508050	WISE	JOSEPH	E MD		8919 PARALLEL	KANSAS CITY	KS	66112	332	500	
105	INTER MEDI	502119	BASOM	THON	A MD		10601 KAW DR	EDWARDSVILLE	KS	66111	12	100	
105	INTER MEDI	516290	BODENSTEINER	DAVID	MD		39TH & RAINBOW	KANSAS CITY	KS	66103	12	12	X
105	INTER MEDI	516162	BOLINGER	ROBERT	E MD	014	SEE AFFILIATE TABLES				49	50	
105	INTER MEDI	500956	DADKHAH	NADER	MD		6013 LEAVENWORTH RD	KANSAS CITY	KS	66104	29	1500	
105	INTER MEDI	516249	DULIN	JOSE	I MD		6013 LEAVENWORTH RD	KANSAS CITY	KS	66104	13	1500	
105	INTER MEDI	516063	DUNN	MARVIN	I MD	014	SEE AFFILIATE TABLES				45	50	
105	INTER MEDI	230894	FORESTER	DAVID	M MD		1217 N 5TH ST	KANSAS CITY	KS	66101	93	1000	
105	INTER MEDI	261303	FORESTER	PRESTON	N MD		1217 N 5TH STREET	KANSAS CITY	KS	66101	103	1500	
105	INTER MEDI	263755	FULLARD JR	JASPER	MD		1217 N 5TH ST	KANSAS CITY	KS	66101	139	1500	
105	INTER MEDI	516127	GREENBERGER	NORTON	J MD	014	SEE AFFILIATE TABLES				48	50	
105	INTER MEDI	261652	HALL	REGINALD	W MD		1217 N 5TH ST	KANSAS CITY	KS	66101	143	1500	
105	INTER MEDI	500452	JEFFERS	RAYMOND	C MD		1217 N 5TH ST	KANSAS CITY	KS	66101	33	200	
105	INTER MEDI	502917	KODURI	VINAYA	K MD		1610 WASHINGTON BLVD	KANSAS CITY	KS	66102	4	100	
105	INTER MEDI	501995	KUMMER	ANTHONY	J MD		KU INTERNAL MED FOUN	KANSAS CITY	KS	66103	42	50	

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10

HMKR463H 07/27/93
ELIGIBLE PCN PROVIDERS
IN WYANDOTTE COUNTY
BY SPECIALTY & NAME

4-12

CASELOAD

005
006 UNIV. OF KANSAS SCHOOL OF MEDICINE-INTERNAL MED.-WICHITA
007 SMOKY HILL FAMILY PRACTICE
008 ST. FRANCIS FAMILY PRACTICE
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HMKR463H 07/27/93

ELIGIBLE PCN PROVIDERS
IN WYANDOTTE COUNTY
BY SPECIALTY & NAME

CTY	SPCD	NUMBER	NAME			GRP AFL	ADDRESS	CITY	ST	ZIP	CASELOAD COUNTS CURR	MAX	S
105	INTER MEDI	503176	MARTIN	PHILIP	E MD		120 N NETTLETON	BONNER SPRINGS	KS	66086	46	1500	
105	INTER MEDI	261145	PAREKH	AJIT	M MD		6013 LEAVENWORTH RD	KANSAS CITY	KS	66104	6	1500	
105	INTER MEDI	519471	PATEL	PRATIP	B MD		1610 WASHINGTON BLVD	KANSAS CITY	KS	66102	49	100	
105	INTER MEDI	503172	PETERSEN	MARK	I MD		120 NORTH NETTLETON	BONNER SPRINGS	KS	66012	26	100	
105	INTER MEDI	516502	PINGLETON	SUSAN	K MD		39TH & RAINBOW	KANSAS CITY	KS	66103	21	50	
105	INTER MEDI	516140	SCHIMKE	R	N MD	014	SEE AFFILIATE TABLES				21	50	
105	INTER MEDI	501075	SMITH	SHADRACH	MD		39TH & RAINBOW	KANSAS CITY	KS	66103	39	50	
105	INTER MEDI	516056	STECHSHULTE	DANIEL	MD	014	SEE AFFILIATE TABLES				15	50	
105	INTER MEDI	516138	STEPHENS	RONALD	L MD	014	SEE AFFILIATE TABLES				17	50	
TOTAL	87								TOTAL		17,375	62,472	

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(5)

HMKR463H 07/27/93

ELIGIBLE PCN PROVIDERS
IN WYANDOTTE COUNTY
BY SPECIALTY & NAME

4-13

BEFORE THE SENATE COMMITTEE ON PUBLIC HEALTH & WELFARE
Senator Sandy Praeger, Chairperson
January 26, 1994

TESTIMONY OF SISTER ANN MARITA LOOSEN
Co-Chair, Managed Care Advisory Committee for Wyandotte County

Senator Praeger and Members of the Committee, thank you for the opportunity to appear before you today.

I appear in my capacity as one of the Co-Chairs of the Managed Care Advisory Committee for Wyandotte County[1]. You know from testimony of previous witnesses that our Committee consists of virtually all of the providers in Wyandotte County that historically have provided physician and hospital services to Medicaid eligible citizens of our community. The Wyandotte County provider community not only supports but welcomes the efforts of the Legislature to achieve reform with respect to the Medicaid Budget. We believe cost savings are available to the taxpayers of Kansas and our difficulty with HB 2047 and the current SRS proposal is not its goal, but the method through which the goal is being pursued.

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[1] Sister Ann Marita is President and CEO of Providence Medical Center, 8900 Parallel Parkway, Kansas City, Kansas 66112, telephone number 913/596-4882.

Senate PH&W
Attachment #5
1-26-94

The hospital providers first learned of House Bill 2047 and its policy recommendation in early Summer of 1993. Initially, the comments that accompanied information about the Medicaid Pilot Project for Wyandotte County essentially stated that the University of Kansas Medical Center (KUMC) was to be the sole provider for all hospital and physician services. This information came to us from a variety of sources including trade associations and other informed observers in Topeka. We, of course, became very concerned upon learning the initial information for several reasons. First, the Wyandotte County providers' generations of experience told us that deprivation of choice for our constituents was clearly not in their best interests and frankly inimical to their interests. Secondly, we could not see how a teaching facility could save money for the State of Kansas. We knew that more than 29,000 medicaid eligible citizens could not be accommodated by KU and thus the plan appeared to us to be ill-conceived from the beginning. Lastly, our efforts to ascertain the intentions of SRS never met with success. We also had grave concern about the physician providers who have been our partners in providing health care to the disadvantaged for several decades. If the initial information we learned was to be true, their practices would be devastated.

Not until December 2, 1993 at a meeting called by SRS in Wyandotte County did we have any real opportunity to learn SRS's intentions. Through December of 1993, we again experienced a certain degree of frustration because of inconsistent information

from SRS. Accordingly, we sought the support of our community's elected officials and we are pleased they have given us this opportunity to be heard.

Senator Praeger we believe a medicaid capitation plan can be devised that is effective, that will contain the principles necessary to protect the interests of the medicaid eligible, and end a divisiveness that is also of concern to the provider community in Wyandotte County. We ask that you introduce and secure clarifying legislation to House Bill 2047 and incorporate in it the requirement that SRS draw upon the wealth of experience available from the two community hospitals in Wyandotte County and its physician providers and the University of Kansas Medical Center. No one knows our community like we do. We will willingly share with SRS our information at no cost. In other words, we want to be included not excluded from the process.

We would hope that any clarifying legislation support the following principles:

1. choice for the patient;
2. establish a partnership between providers, clients and government;
3. implement a careful and deliberate planning process that includes <u>all</u> of the historical providers; and
4. after negotiations, fair payment terms and conditions to providers.

If a sole provider concept is the true goal of SRS this would indeed be unfortunate. Both community hospitals together employ in excess of 2,000 people, 70%-80% of whom live in Wyandotte County. In my opinion, lay offs would be unavoidable. Physician providers in many instances would see substantial portions of their patient population disappear and perhaps be forced to re-locate their practices outside of Wyandotte County. Lastly and most importantly, "choice" for patients would be eliminated. This would create hardship for many patients and it would also deprive them of the dignity that accompanies choice.

I would be pleased to answer any questions that any of you have.

MANAGED CARE SPEECH FOR 119 BILL

Thank you for the opportunity to address the issue of Managed Care, this morning.

I would like to preface my brief statement by acknowledging the significant contribution KUMC has provided to our community and state. Our concerns are not a reflection on the institution or the individuals which we believe are dedicated to the public good. However, if you were to place yourself in our position, and you were told by the parties responsible for implementation, of the proposed Managed Care Pilot Project the following:

1) This project is a done deal;
2) It <u>will</u> be competitively bid;
3) <u>KU is not</u> the sole source recipient;
4) No, It **<u>will not</u>** be competitively bid KU <u>is</u> the sole source;
5) We don't know about Managed Care, but we still must implement this by July;
6) You will be part of the process, a local resident has already been contacted and selected to sit on the Advisory Board. Oh, we didn't know that he does not live in the state anymore;
7) You can form a local advisory group, but only we will chose the members who sit on the formal state advisory group despite your solicited recommendations.

Ladies and gentleman this is only a small sample of what we have experienced in the process which has taken place to date.

The proposed Managed Care Pilot Project in its current form is noble in concept but deeply tainted in process. As illustrated by the SRS Managed Care Plan of December 2,1993. It is vital that a successful Managed Care project be community based and encompass cooperation and communication.

The process to date as implemented by SRS is absent of these qualities. On numerous occasions, attempts have been made by the Wyandotte County Community Advisory Group to become part of the process. The response has been limited at best. Overtures were made to KUMC to meet and develop a mutually agreed upon plan, these overtures were ignored.

We have spoken of the economic impact of the pilot project, we have spoken of the lack of process regarding its implementation, but the essence of this issue is the elimination of individual choice.

Senate PHW
attachment #6
1-26-94

All parties profess that they do not wish to hinder individual choice. Yet, the lack of communication, and a policy of selective dialogue from the parties involved indicates otherwise.

The Medicaid clientele of Wyandotte County is largely an indigent population. Our economic base illustrates this fact. This population base consists primarily of minority individuals. To totally disregard choice in this matter lends one to perceive a very disturbing practice of thought is occurring. Quite often those who project to embrace the concept of, cultural diversity in philosophy are negligent in exercising its tenets. That basic tenet being, appreciation of individual choice. Individual choice of medical services maybe based upon personal preference or quality of service, either way it is still a fundamental element of our personal being to decide.

This bill as presented eliminates this fundamental right. It is wrong to herd a group of people in one direction for economic gain and convenience. It is wrong to use a select group as a tool for learning or a testing ground for knowledge, with personal choice being disregarded.

In January of 1865 the 13th amendment eliminated the possibility of legalized institutions without choice. In January of 1994 we are hinging on revisiting some of the same components which we found so unconscionable then. You may think this premise is outside the issue, but I relay to you today this assertion of non-choice and the comparison are apropos. In 1865 some people were told when, where and how their children were to be brought into this world. Is this not what the Managed Care Pilot Project does in its current form. If we can not even meet to discuss openly as governmental peers or Health care providers, what does this say to those local doctors, patrons, and hospitals about this process. The lessons of yesterday should provide the knowledge of today. When a process no matter how well intended eliminates choice, the result can only be disaster, no matter how noble the concept. I'm sure in 1950 medical science believed that radiation testing on humans in its limited form would be beneficial to mankind. To provide the alternative of choice to the individual would only hinder the time line of progress of the project. Today we see the fallout from the elimination of choice in that process. The matter which you hear testimony on today to **us**, is just as significant, and has the same potential impact upon our community and our lives. I understand the good intentions of this bill. I believe in the deep motivation of Public good from which it was spawned. I merely ask for our community to not let this project go any further as it stands because of it's misinformation, lack of process, and lack of choice.

Amend the law or at least the process so we won't have to look back 2 years from now and explain to our family, friends and constituents, that their person of choice was not a factor in a law which governs their lives.