Approved: 3-10-94
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 February 24, 1994 in Room 526-S of the Capitol.
All members were present except:
Committee staff present: Norman Furse, Revisor of Statutes
William Wolff, Legislative Research Department
Emalene Correll, Legislative Research Department
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:
Senator Pat Ranson
Walter H. Crockett, Kansas AARP
Jean Hall, Kansas Association of Centers for Independent Living
Robert Epps, SRS
Robert C. Harder, Secretary, Kansas Department of Health and Environment
Jerry Slaughter, Executive Director, Kansas Medical Society
Tom Bell, Kansas Hospital Association

Others attending: See attached list

Action on Minutes

Senator Hardenburger made a motion to approve the minutes of February 15, 16, 17 and 18, 1994, seconded by Senator Walker. The motion carried.

Action on SB 683 - Person licensed to practice medicine and surgery required to provide patient prior to a breast implant certain information relating to the procedure

Senator Ranson addressed the Committee and provided a balloon of the bill showing proposed new language to be inserted in Section 1, line 17, after the word, "the," and striking language in Section 1, after the word "the" through line 38. Senator Ranson noted that basically what the amendment does is say 'yes' there will be disclosure, the patient will sign a form saying, "I have been given all of the information," and the Board of Healing Arts have indicated they will be willing to work on a disclosure and statement. Women who chose to have a breast implant will be fully informed, and then it is their choice. (Attachment 1)

Senator Ramirez made a motion to adopt the balloon amendments as presented, seconded by Senator Hardenburger. The motion carried.

Senator Ramirez made a motion the Committee recommend **SB 683 as amended** favorably for passage, seconded by Senator Hardenburger. The motion carried.

SB 521/Report of subcommittee/Health Systems Reform

The Chair expressed concern that all of the conferees who were at the hearing Wednesday, February 23rd on **S B 521** were not able to testify that day and announced the hearing would continue Monday, February 28th. The Chair also announced that if there were conferees at the meeting that could not come back Monday, their testimony would be heard today.

The Chair reported that the subcommittee met upon adjournment Wednesday, February 23rd, and that it was agreed to increase the number of members on the Kansas health care reform legislative oversight committee from 6 to 10, add as advisors to the Commitee the Secretary of SRS and Budget Director, and the possibility of consumers be a part of each of the other subcommittees rather than a separate subcommittee. Copies of the health systems reform proposal were made available to those at the meeting. (Attachment 2)

A member questioned if this proposal would be a substitute for **SB 521**, an amendment to **SB 521** or a new bill. Robert Harder, KDHE, noted that the possiblility of a new bill would be a better route.

Walter H. Crockett, Kansas AARP, testified before the Committee in opposition to **SB 521** and noted the first concern with the bill is that it is not a real proposal for health care reform, but would merely set up an administrative agency to develop a program for such reform. (Attachment 3)

During Committee discussion, Mr. Crockett noted that his organization would not be supportive of another health care legislative committee and is also disappointed with the 403 Commission's proposed legislation. He noted that it is probably too late to have any health care reform bill implemented this legislative session, and would

prefer that the legislature work out a detailed plan like that of Vermont, Minnesota or Missouri, so that some sort of a plan would be in place if a federal proposal is implemented. He noted that his organization's fundamental concern is universal coverage, and they are working at the federal level in an attempt to have coverage for preventive care, home and community based long term care, and some assistance in prescription drugs as well as acute care. As far as funding for any plan, Mr. Crockett noted his organization does not have specific answers.

Jean Hall, Kansas Association of Centers for Independent Living, appeared in opposition to **SB 521** noting that the bill attempts to extend an inadequate health care system to a greater number of people, rather than improving it, and that the bill is a band-aid approach to a problem that requires radical change. (Attachment 4)

The Chair announced that the hearing on **SB 521** will be continued Monday, February 28th, at 9:00 a.m.

Hearing on SB 759 - Establishing a program of providing actute care medicaid services through a system of managed care

Robert Epps, SRS, submitted written testimony on **SB 759**, (Attachment 5), and stated SRS is generally in support of the bill, but their principle concern is that a 14 member task force which gives authority to negotiate contracts with another entity would seemingly delute the authority of the secretary of SRS. He noted that the state of Oklahoma attempted a similar program a year or two ago, but does not know precisely what their experiences have been and noted that they are having problems by combinding state employees with their Medicaid population. He also stated that our Medicaid cost of $2,195 on an annual basis is $391 less than the average health care insurance premium for state employees which is $2,586, and that some cost avoidance may not be possible. Benefits were not compared on a detailed basis, and he noted that benefits on the Medicaid side would not be available for state employees without some increase. Mr. Epps felt cost shifting would result from funding governmental health care programs.

Staff questioned Mr. Epps if the Kansas State Employees Commission as is currently structured would have the capability, expertise, and staff to handle this kind of program, and Mr. Epps noted that it could pose administrative problems.

Robert C. Harder, KDHE, submitted written testimony in support of **SB 759** (Attachment 6) and noted that the option the Health Care Commission would exercise would be that of a purchasing agent for Title XIX, acute care, and that they would be working cooperatively with SRS on the item of purchased care. Dr. Harder suggested that when managed care is talked about, serious consideration should be given to capitation, because at that point you would enter into a serious discussion with the providers, and if the providers do not want to enter into a capitation kind of plan, then quite likely there wouldn't be a deal. He also commented that one shouldn't get distracted on the question of whether Kansas should have an acute care system or not.

A member questioned why the managed care pilot projects should be scrapped, and it was noted that the expertise to develop manage care does not exist in SRS by itself and that a much broader approach is needed to develop managed care on a statewide basis. The task force could recommend that implementation be over a period of time and in effect be implemented like a pilot project by starting in the larger urban centers where there are the majority of Medicaid clients and then extending it statewide. The bill is drafted to give enough flexibility for the task force to come back and make recommendations. A request was made by a member of the Committee that more information on managed care be provided to those members who did not receive enough information.

Jerry Slaughter, KMS, addressed the Committee in general support of **SB 759** but noted two concerns: first, that all parties, including state government, the provider community, Medicaid recipients and others, have similar expectations and goals about moving the Medicaid system into managed care, and second, that there be proper funding of such a managed care system so that it would not fail. (Attachment 7)

Concern was expressed by a member if providers would sign up for the $2,195 range.

Tom Bell, KHA, submitted written testimony (Attachment 8) and commented that if **SB 759** were implemented, and federal waivers would have to be applied for, then HCFA should be assured that no more than 95% would be paid as is currently done.

A minority report was submitted on **SB 521**. (Attachment 9)

The meeting was adjourned at 11:00 a.m.

The next meeting is scheduled for February 28, 1994.

GUEST LIST

COMMITTEE: SENATE PUBLIC HEALTH & WELFARE DATE: 2-24-94

NAME	ADDRESS	COMPANY/ORGANIZATION
Walter H. Crockett	1400 Lilac Lane #202 Lawrence KS 66044	AARP
George Goebel	Topeka	AARP Health Care Reform
Anne Kimmel	Topeka	AARP
Jean Hall	Independence, Inc 1910 Haskell, Lawrence	representing Kansas Assoc. of Centers for Indep. Living
Michael Todd	"	representing Health Care Reform Coalition
Lucille Parli	(P.O. 292 Topeka) Kansas Assoc. for the	Blind & Visually Impaired
Sheryl Tatroe	TOPEKA	Kansas Mental Health Coalition
Terry Larson	Topeka	Kansas Alliance for the M.I.
ALAN COBB	WICHITA	DELTA DENTAL
BD ROLING	WICHITA	DELTA DENTAL
Dave Cheney	Topeka	HCC
Gary Counsolman	Topeka	KCA
Sharon Couch	Topeka	KCA
Rich Guthrie	KC	Health Midwest
RAY SCHER	TOPEKA	CITIZEN
[illegible]	Topeka	[illegible]
Bill Sneed	TOPEKA	HIAA
LARRY MAGILL	TOPEKA	KAIA

Senate B.P. #683
Attachment #1
2-24-94

Session of 1994

SENATE BILL No. 683

By Senator Ranson

2-4

AN ACT concerning the healing arts act; requiring persons licensed to practice medicine and surgery to provide information to certain patients concerning breast implants; amending K.S.A. 65-2836 and repealing the existing section.

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

New Section 1. (a) Before a person licensed to practice medicine and surgery operates on a patient to insert a breast implant, the person licensed to practice medicine and surgery shall inform the patient of the ~~advantages, disadvantages and risks associated with a breast implantation.~~

~~(b) The board of healing arts shall:~~

~~(1) Provide a standardized written summary in layman's language that:~~

~~(A) Contains all the information on breast implantation generally contained in the information sheet for the breast implant; and~~

~~(B) discloses side effects, warnings and cautions for a breast implantation;~~

~~(2) update as necessary the standardized written summary; and~~

~~(3) distribute the standardized written summary to each hospital, clinic and physician's office and any other facility that performs breast implantations.~~

~~(c) A person licensed to practice medicine and surgery satisfies the requirements of subsection (a) of this section if:~~

~~(1) The person licensed to practice medicine and surgery provides the breast implantation patient with the standardized written summary described in subsection (b) of this section;~~

~~(2) the patient receives the standardized written summary five days before the breast implantation operation; and~~

~~(3) the patient signs a statement provided by the board of healing arts acknowledging the receipt of the standardized written summary.~~

(d) This section shall be part of and supplemental to the Kansas healing arts act.

Sec. 2. K.S.A. 65-2836 is hereby amended to read as follows: 65-2836. A licensee's license may be revoked, suspended or limited, or the licensee may be publicly or privately censured, or an applicant known risks associated with breast implantation, as specified in the standardized summary supplied by the board of healing arts. The board shall develop and distribute to persons licensed to practice medicine and surgery a standardized summary of the risks associated with breast implantation known to the board at the time of distribution of the standardized summary. The standardized summary shall contain information on breast implantation generally contained in the breast implant product information insert, and shall disclose the known side effects, warnings and cautions associated with breast implantation. Nothing in this subsection shall be construed to empower or authorize the board to restrict in any manner the right of a person licensed to practice medicine and surgery to recommend a method of treatment or to restrict in any manner a patient's right to select a method of treatment. The standardized summary shall not be construed as a recommendation by the board of any method of treatment. The preceding sentence or words having the same meaning shall be printed as a part of the standardized summary. The provisions of this subsection shall not be effective until the standardized written summary provided for in this subsection is developed and distributed by the board to persons licensed to practice medicine and surgery.

(b) A person licensed to practice medicine and surgery is in compliance with and satisfies the requirements of subsection (a) of this section if: (1) the person licensed to practice medicine and surgery provides the breast implantation patient with the standardized summary five days prior to operating to insert a breast implant; and (2) the patient signs a statement provided by the board acknowledging the patient's receipt of the standardized summary.

(c) For the purposes of this section, in the event of any claim by a breast implantation patient or any person on such patient's behalf against a person licensed to practice medicine and surgery, it shall be conclusively presumed that any patient who received the standardized summary provided for in subsection (a) shall have been fully informed regarding the breast implantation procedure and given an informed consent to the same.

THE JOINT COMMITTEE ON HEALTH SYSTEMS REFORM

Section 1. Preamble. Health care reform for all Kansans is a matter of general public interest. It is therefor a matter that should be addressed by those persons elected by the voters to make public policy. The prospect of federal legislation affecting state laws and regulations requires that the state have the legislative and administrative expertise to promptly make the necessary adjustments in both laws and regulations as required by federal law. Further, regardless of the federal proposal enacted, each such proposal relies ultimately on the state for implementation in the crucial areas of insurance reform, quality assurance, availability of service, and administrative structure to implement the reform program. The legislature must be prepared to respond timely but deliberately to safeguard the public health and welfare of all Kansans.

Sec. 2. Health Care Reform Legislative Oversight Committee. There is hereby created the Kansas health care reform legislative oversight committee, hereinafter "committee," to oversee the necessary changes in state laws and regulations made necessary by federal law and, to the fullest extent possible, implement health care reform specific to Kansas needs. The committee shall be composed of two persons appointed by the speaker of the house of representatives, one appointed by the minority leader of the house of representatives, two appointed by the president of the senate and one appointed by the minority leader of the senate. The secretary of health and environment and the commissioner of

Senate PHEW
attachment #2
2-24-94

insurance shall be advisors to the committee and shall serve as directed by the chairperson, including work with related subcommittees created by the committee. The chairperson shall be elected annually by the committee and alternate between the senate and the house of representatives. The committee shall take action only by majority vote of the entire committee whether present and voting or not and in case of a tie vote, the vote of the chair shall decide the issue. The committee shall be designated a standing joint committee of the legislature and shall have such powers and duties as hereinafter provided. Funding of operations of the committee shall be made by appropriation of the legislative coordinating council and approved by the council. Administrative support for the committee shall be provided by the division of legislative services.

Sec. 3. Powers and Duties. (a) (1) Duties of the committee shall be to examine changes in federal laws affecting Kansas and propose such changes in Kansas laws and regulations as are necessary to meet the federal requirements.

(2) Cooperate and interact with agencies of the federal government responsible for health care reform.

(3) Consider all health care financing and delivery options now in effect taking into account the actions of other states and the federal government.

(4) Work cooperatively with all relevant state and federal agencies, health care providers, payors and consumer groups in the development of an integrated health plan for all Kansans.

(5) Receive, analyze and make recommendations related to the state health care data base developed by the health care data governing board.

(6) Develop plans for health care cost containment.

(7) Study and make recommendations for legislative action to integrate health care financing and coverage with other states.

(8) Recommend legislative actions necessary to assure accessibility of services to residents of underserved areas.

(9) Provide recommendations if federal or state law require inclusion of the medical care component of workers compensation and automobile insurance into all inclusive health care coverage.

(10) Make recommendations on tort reform for medical liability and for state antitrust reform and federal antitrust modifications.

(b) The committee may appoint advisory subcommittees as it deems appropriate but shall at least name the following:

(1) Administrative subcommittee. This subcommittee will be composed of the secretary of health and environment, the secretary of social and rehabilitation services, the secretary of aging, and such other state or local governmental agencies as are named by the committee;

(2) Insurance subcommittee. This subcommittee shall be composed of the commissioner of insurance, a representative of a domestic insurance carrier, a representative of a foreign insurance company, a representative of the managed care industry, and such others as are named by the committee;

2-3

(3) Employer subcommittee. This subcommittee shall be composed of a representative of statewide business organization having large and small employer members, a representative of an organization having only small employer members, a representative of organized labor, and such other members as are named by the committee;

(4) Provider subcommittee. This subcommittee shall be composed of a representative of a statewide physician group, a statewide nursing group, a statewide hospital group, and such other provider groups as the committee shall name; and

(5) Consumer subcommittee. This subcommittee shall be composed of representatives of consumers of health care in this state as named by the committee.

(c) All subcommittees shall meet and report at the direction of the committee, but in no event shall the subcommittees report less than quarterly. All meetings shall be subject to the Kansas open meetings act.

Sec. 4. Funding and Staff. From moneys appropriated for the legislature, the committee shall employee an executive secretary who shall be in the unclassified civil service and receive compensation as approved by the legislative coordinating council. The executive secretary shall act as staff to the committee and its subcommittees and shall serve as liaison with the state agencies and the office of the governor. All officers and employees of the state shall provide such information and assistance as may be deemed necessary by the joint committee.

Other staff assistance shall be provided by the office of the revisor of statutes, the legislative research department and such other legislative offices and employees as may be directed by the legislative coordinating council.

Sec. 5. Committee Designated Contact. The health care reform legislative oversight committee is hereby designated the contact committee for the state of Kansas with reference to federal health care reform measures. All official acts of the state of Kansas, not otherwise required by another statute, with regard to health care reform, will be performed by the chairperson of the committee or the chairperson's designee.

Sec. 6. The Committee May Introduce Legislation. Legislation introduced by the committee may be directly referred to the floor of either house by the president of the senate or the speaker of the house of representatives.

Sec. 7. Sunset. The provisions of this act shall expire on June 30, 1998.

Sec. 8. Repealer. Repeal the joint committee on health care decisions for the 1990's.

Sec. 9. Effective Date. This act shall take effect and be in force from and after its publication in the Kansas register.

TESTIMONY ON S.B.521, TO ESTABLISH A KANSAS HEALTH ALLIANCE, AND RELATED MATTERS.

Walter H. Crockett, Kansas AARP, Feb. 24, 1994

The Legislature does not permit people who testify before it to sit on the fence; they must either support a bill or oppose it. This caused me a problem because there are aspects of the Senate Bill 521 that it seemed Kansas AARP could support. We applaud Secretary Harder for preparing this bill, thereby ensuring that this committee will consider in this session at least one bill that deals with health care reform. But some aspects of the bill were so unclear that we could not decide whether AARP should support or oppose them. And since there were one or two aspects that AARP would clearly oppose, I signed up as an opponent of the bill. I am now glad that I did: after Secretary Harder's testimony yesterday, it is clear that AARP opposes this bill.

Our first concern about this bill is that it is not a real proposal for health care reform; it would merely set up an administrative agency to develop a program for such reform. For more than four years, we in Kansas AARP have followed closely the activities of the Senate Committee on Public Health and Welfare, of the House Committee on Public Health and Welfare, of the Joint Committee on Health Care Decisions for the 90's, of the Kansas Commission on Health Care, Inc., and of various non-governmental organizations, including our own, which have studied in detail the crisis in health care in our state and nation. We have studied a variety of proposals about how to deal with that crisis. We had expected by this time to see legislation that would establish a specific program for health care reform in Kansas, paralleling programs that are being developed in states not unlike our own--for example, Vermont, Minnesota, Oregon, Washington, even Missouri. We expected, that is, a proposal for health care reform that could be implemented whether or not the Federal government acts on this issue, one that would blend with the federal program if one passes or, if not, would at least make some movement toward reform in our own state. We are deeply disappointed that no such proposal has been made. Instead, the present bill, and the other legislation discussed in this committee yesterday, would establish commissions to monitor actions at the federal level and recommend measures to implement federal programs in Kansas. Thus, basic decisions about health care reform in our state would be postponed to some later date.

Let me elaborate on this assessment by testing the proposed bills against the criteria by which AARP assesses proposals for health care reform.

The first criterion of real health care reform is that it should provide <u>universal coverage</u> of all Kansans. As Senate Bill 521 was written, it was unclear whether it would provide universal <u>coverage</u> for health care or universal <u>access</u> to health care. Kansas AARP stands unequivocally in favor of universal coverage and against mere universal access. In his comments yesterday, Secretary Harder suggested that he wanted the bill to apply, not to all Kansans, but to "selected Kansans." That is, far from providing universal coverage, the bill would not even

Senate PHEW
attachment #3
2-24-94

provide universal access to health care. Kansas AARP is firmly opposed to any legislation that does not include universal coverage.

Second, real health care reform must provide a comprehensive package of benefits, including preventive care as well as assistance with long-term-care and prescription drugs. It is not clear what benefits would be included in Senate Bill 521. Would they be the ones now included in the current state employee benefit package? If so, do these meet our criterion? Before we can support this bill or any other, the benefits need to be spelled out in detail.

Third, because the cost of medical care has been increasing at two or three times the rate of inflation, real health care reform requires cost containment. This bill enjoins the Kansas health alliance to develop plans for cost containment but provides no hint of how this is to be accomplished nor any estimate of the likelihood of success.

Fourth, realistic health care reform must be achieved by fair and affordable financing. No details are given in this bill for financing the Kansas health alliance or the reforms it institutes.

Fifth, Kansas AARP is fundamentally committed to the importance of consumer involvement in governing the health care system. The health alliance proposed in Senate Bill 521 falls far short of achieving such involvement. It would consist of nine members. Three of these are specified government officials: the Commissioner of Insurance, and the Secretaries of Administration and of Health and Environment; the other six members would be drawn from nine different sources, at least seven of which are agencies of state, county, or local government. In short, all nine members could be government officials, department heads, or employers; there is no requirement that any of them be employees or general consumers. An advisory board is proposed, 51% to represent consumers and 49% health-care providers, but the size of that board could swell to as many as 100 members. We doubt that a board of this size and composition could develop a strong consensus on issues of health care reform; further, as it is advisory only, the alliance would be under no requirement to follow its recommendations. Similarly, if a commission or an oversight committee is to be established, as proposed in this committee's discussion yesterday, we believe that consumers should be represented at every decision-making level.

Further, as regards Senate Bill 521, we do not believe that the policy-making body for a reformed health-care program in Kansas should be housed in a single department of state government. Such a body would have responsibilities that are important enough to justify establishing it as an independent administrative entity, one which cooperates with and supports every relevant department in state government but which is under the direct authority of the governor and the legislature, not of one or more departmental executives.

In summary, although we applaud the willingness of Secretary Harder to tackle the problem of health care reform, we cannot support this bill. It is not clear that it will provide universal coverage to all Kansans. Its benefits package is not clear. It gives no indication of how cost containment might be accomplished nor of how such reform as takes place

3-2

is to be financed. It does not ensure effective consumer representation in health-care reform policy. And we disagree with the proposal to place the health alliance under the jurisdiction of a single department.

As to the proposals advanced yesterday by Senators Praeger and Walker, to the extent that they do not contain specific proposals for health care reform, we are disappointed. We hope that some bill will be passed in this legislature that at least puts the state on the road to real health care reform in the very near future.

3-3

TESTIMONY TO THE
SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
SENATOR SANDY PRAEGER, CHAIRPERSON
FEBRUARY 23, 1994

My name is Jean Hall. I am representing the Kansas Association of Centers for Independent Living. I am also speaking as a person with a disability who has experienced discrimination by the health insurance industry on numerous occasions.

In theory, Senate Bill 521 seems reasonable. In practice, however, it does not work. The 1992 legislature passed a bill that would allow agencies like Centers for Independent Living, Community Retardation Centers, and Community Health Centers to buy into KPERS. Last year, KACIL and the Kansas Association of Rehabilitation Facilities attempted to obtain health insurance for their member agencies through the state system. Because of many demographic factors, including the fact that these agencies employ a high percentage of people with disabilities, the premiums presented were prohibitive. For smaller groups, the premiums would be even greater. Availability of insurance means nothing if people can't afford to get coverage.

Last week, a coalition representing more than 100 organizations presented a position on Principles of Health Care Reform to this committee which enumerated the most basic of requirements for an acceptable health care system. One of the requirements is affordability. As discussed, Senate Bill 521 does not meet this requirement. Another requirement is comprehensive services. The plan administered through the state has become less and less comprehensive over the years and, based on other legislation being introduced, the level of coverage will probably continue to decrease. Having insurance that doesn't cover your needs is like having no insurance at all.

Senate Bill 521 attempts to extend an inadequate system to a greater number of people, rather than improving the system. Essentially, it is a band-aid approach to a problem that requires major surgery. KACIL appeals to you to vote against this bill, and any other bill, that does not meet the needs addressed here and in the Principles paper presented to you last week. To insure means "to make safe or secure;" the people of Kansas deserve a system that makes them secure. Please make such a system available.

Thank you for this opportunity to speak today. I would be willing to stand for questions.

Senate PH&W
attachment #4
2-24-94

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

Senate Public Health and Welfare Committee

Testimony on Senate Bill 759
Regarding the Medicaid Managed Care Program

February 23, 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 Chairman and members of the committee, I thank you for this opportunity to testify on Senate Bill 759. This bill repeals SRS authorization to pilot managed care in two counties and would require Managed Care Services be procured through Kansas state employees health care commission.

To maintain federal funding, SRS as the single state agency will need to maintain responsibility and authority for Medicaid policy, regulations, and the state plan.

It is important for the consumer of Medicaid service programs to serve on the advisory committee because of their need for special services.

The Medicaid program is a highly efficient program with 4 percent of the total costs attributed to administration. The commission will need to assure that both administrative and service costs continue to be efficient and reasonable.

SRS must continue to administer benefits not provided by through managed care contracts such as long-term care services. Since this bill addresses only acute care, SRS must continue to search for solutions to the escalating long-term care costs. The lack of community resources hinders the substitution of community care for institutional care.

With the passage of this bill, SRS would also be able to take advantage of the contracting expertise in the health care commission.

In summary, the Department of Social and Rehabilitation Services expects to gain several benefits from the passage of Senate Bill 759. SRS is very interested in seeking innovative ways to provide access to quality health care for beneficiaries.

Donna L. Whiteman
Secretary

Senate PH&W
attachment #5
2-24-94

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment
Robert C. Harder, *Secretary*

Testimony presented to

Senate Public Health and Welfare

by

The Kansas Department of Health and Environment

Senate Bill 759

Senate Bill 759 provides a mechanism for the acute care portion of Title XIX to be studied and changed to some type of managed care concept. The implementation of this concept would be through the Kansas State Employees Health Care Commission.

Several states have begun to move in this direction. It is important to begin to look at the challenges related to the delivery of medical services to the Medicaid population.

It is logical to have the Kansas State Employees Health Care Commission serve as the lead agency to help in formulating a strategy because of its ten (10) years of experience in purchasing medical services. It is also logical to have a broad based group of interested parties to review this total process to ensure ownership and participation in the final outcome.

Also, the Secretary of the Department of Social and Rehabilitation Services remains an active player because of the close interaction which will be necessary between federal and state government.

I support Senate Bill 759 as an important step in the further review of medical care issues.

Robert C. Harder
Secretary
KS Department of Health and Environment

Senate PH&W
attachment #6
2-24-94

KANSAS MEDICAL SOCIETY
623 SW 10th Ave. • Topeka, Kansas 66612 • (913) 235-2383
WATS 800-332-0156 FAX 913-235-5114

February 23, 1994

TO: Senate Public Health and Welfare Committee

FROM: Jerry Slaughter
Executive Director

SUBJECT: SB 759; Concerning a Managed Care Program for Medicaid

The Kansas Medical Society appreciates the opportunity to appear today as you consider SB 759, which would require that all Medicaid acute care services would be delivered through a managed care program statewide. The bill would also empower the Kansas State Employees Health Care Commission to be the agency responsible for contracting for the managed care program.

While we are generally supportive of the concept of moving the state's Medicaid program into a managed care delivery system, we must express a couple of concerns. First, it is important that all parties, including state government, the provider community, Medicaid recipients and others, have similar expectations and goals about moving the Medicaid system into managed care. Experts have previously testified that managed care in and of itself will not produce significant savings in the Medicaid program. Experience from other states has shown that a Medicaid managed care system can, *over the long run*, produce savings of 5-7% over the current delivery system. While that is not an insignificant amount, it points out that the primary motivation for moving to managed care in Medicaid cannot be solely that of cost savings.

A managed care system can improve access and outcomes by providing more consistency and comprehensiveness to the care Medicaid patients receive. Managed care can also give the state better predictability of costs, which should help in the budgetary process. One of the ways it impacts costs is by assuring that Medicaid patients receive only care that is medically necessary, and that they receive it in the proper setting. Beyond that, it is a little unrealistic to expect substantial savings in the program just by moving to a system of managed care.

We have a major concern that the move to a managed care system will fail if it is not properly funded. Assuming the new system will be capitation-based, if the capitation rate is inadequate, the new system may not be an improvement over the current system, especially in its attempts to improve access to care for Medicaid patients. Physicians are more than willing to help the state find solutions to the Medicaid problem, including moving to a statewide managed care system. However, to be successful, the program must be adequately funded, and all parties must have a thorough understanding of shared goals. We appreciate the opportunity to offer these comments, and would be happy to respond to any questions.

JS:ns

Senate P H & W
attachment # 7
2-24-94

KANSAS HOSPITAL ASSOCIATION

Donald A. Wilson
President

Memorandum

February 23, 1994

TO: Senate Public Health and Welfare Committee

FROM: Kansas Hospital Association

RE: SB 521 and 759

The Kansas Hospital Association appreciates the opportunity to present testimony regarding Senate Bills 521 and 759. Senate Bill 521 would, among other things, establish the "Kansas health alliance" to purchase health care for a number of different entities in Kansas. Senate Bill 759 would direct the development of a statewide medicaid managed care system.

Although these two bills contain obvious differences, they contain one important similarity--the concept of moving the state Medicaid system toward a managed care model. Senate Bill 521 accomplishes this by authorizing the newly created Kansas health alliance to be the purchaser of Medicaid services for the state, while Senate Bill 759 creates a statewide task force to develop the guidelines for the implementation of the program. We will concentrate our remarks on this issue.

All states, including Kansas, have experienced dramatic increases in the cost of their Medicaid programs, severely straining this program designed to provide health care for the poor. In response to cost and access problems, states have increasingly turned to managed care delivery systems. Managed care in Medicaid is not a single health care delivery plan, but rather a continuum of models that share a common approach. At one end of the continuum are primary care case management models, which are similar to traditional fee-for-service arrangements except that providers receive a per capita management fee to coordinate a patient's care. At the other end are prepaid or capitated models that pay organizations a per capita amount to provide or arrange for all covered services. The proposals before the committee envision a program closer to the latter end of the continuum.

Although Medicaid managed care may mean different things to different people, it is important to note what the term should not denote. It should not mean a process where services provided to Medicaid recipients are simply offered up to the lowest bidder. The first attempt at managed care in the Arizona medical assistance program started in this

Senate PHW&E
Attachment # 8
2-24-94

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manner and ended in failure. Medicaid managed care should not mean a process that is developed without the involvement and the investment of the entire community. Committee members have heard of the problems associated with the pilot programs authorized during the 1993 session, some of which stem from the fact that the entire community was not sufficiently involved. A Medicaid managed care program should, however, be one that is sensitive to the demographics of Kansas, one that respects patient choice as much as possible, and one that encourages collaboration between the public and private sectors, such as the model proposed in SB 759. A successful program could potentially resemble the Medicaid managed care project in Philadelphia, as detailed in the attached article.

Recently, a U.S. General Accounting Office report summed up the lessons learned by states that have ventured into Medicaid managed care:

> First, in planning the implementation of a managed care program, states have found that problems can arise if they move forward too quickly, do not have staff expertise, and not developed a community base of support. Second, if states decide to move a greater number of Medicaid beneficiaries into managed care settings by making enrollment mandatory, they must obtain federal approval. Third, states have had difficulty encouraging the participation of commercial managed care plans, such as health maintenance organizations. Finally, to make managed care work, states have to develop education programs so that beneficiaries will understand how to access services in this unfamiliar environment.

MEDICAID: States Turn to Managed Care to Improve Access and Control Costs; General Accounting Office, March 1993.

We think the GAO study should be instructive to any state considering Medicaid managed care options.

Thank you for your consideration of our comments.

Philadelphia, Pennsylvania

MAINSTREAMING MEDICAID

What would it take for six urban teaching hospitals to sit down and collaborate? In North Philadelphia, the precipitating events didn't occur in boardrooms but out in the community.

First, hospital executives needed look no further than their overburdened emergency departments to see the rising toll of violence, drug abuse, high infant mortality and teen-age pregnancy in the area—which includes more than half of the city's population and some of its poorest neighborhoods.

If that wasn't troublesome enough, the Pennsylvania Legislature signaled plans to cut back already insufficient Medicaid funding.

Four hospitals (two others later joined up) turned to managed care for a solution, developing an HMO for Medicaid recipients that would begin to address problems of inadequate access and uncoordinated care. After securing a crucial three-year, $1.2 million grant from the Robert Wood Johnson Foundation to cover administrative and marketing expenses, Health Partners of Philadelphia was launched in 1987.

The participating hospitals are Albert Einstein Medical Center, Episcopal Hospital, Frankford Hospital, Medical College Hospitals, St. Christopher's Hospital for Children, and Temple University Hospital. In effect, each functions as a staff model HMO under the plan.

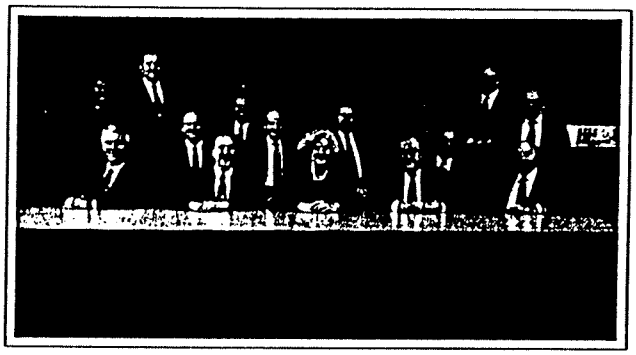
Health Partners' growth speaks to its success. By the third year, the plan had attracted 10,000 enrollees. Today, it serves 75,000 people at 200 sites, with 350 primary care physicians.

"We had a lot of skeptics in the beginning who weren't sure that medical assistance recipients would give up their Medicaid cards to join the more disciplined system that an HMO requires," says Barbara Plager, president and CEO of Health Partners. "But support from physicians began to solidify, and it became clear that the hospitals were committed to developing a system that's competitive with fee-for-service."

Primary care a strength

A defining strength of Health Partners is the fact that enrollees carry a special card bearing the name of the primary care physician they've chosen. In fact, Plager adds, the plan's reputation for comprehensive pediatric care has helped draw adult enrollment.

But assembling the needed amount of primary care physicians required other new solutions. The hospitals responded by extending medical staff privileges to non-teaching physicians in the community—a first for them.



Some of the partners behind Health Partners: Barbara Plager, the managed care plan's president and CEO (center), with 14 colleagues and board members.

Plager is matter-of-fact about how the hospitals and their teaching faculties came to grips with that change in policy: "When it became clear that it needed to get done, it got done."

Knowing that some community physicians prefer to limit their practices to office-based care, the plan developed an outpatient primary care arrangement that contractually links community physicians to inpatient physicians to provide coverage for Health Partner enrollees.

Plager says the plan has given the hospitals valuable lessons about managing their resources under a capitated managed care system. Still, she emphasizes that Health Partners isn't interested in penalizing the hospitals for their mistakes along the way by inflicting damage that might reduce access or jeopardize quality.

Instead, the plan works with affiliated hospitals to improve utilization management problems, such as unauthorized procedures or ED visits. To handle most problems, Health Partners offers 24-hour emergency advice and member service lines.

A recent example involved an increase in border babies in Health Partner hospitals. Says Plager, "The typical response of a state Medicaid plan would be to deny payment, if the baby is no longer in the hospital for medical reasons. But the problem was in the placement of these infants. We worked with the hospitals to analyze the problem and then improve foster placement procedures with the city."

The joint approach calls for early identification of a potential border baby situation—which starts wheels turning with the plan and the hospital to expedite foster care placements with city social service officials.

Supporting moms to-be

Health Partners also attempts to reduce neonatal tragedies by enrolling expectant moms in its "Little Partners" program, which links the women with volunteers who have overcome similar struggles.

In addition to reinforcing positive parenting roles and providing advice, the volunteers make sure enrollees are receiving proper nutrition and support at home—as well as keeping prenatal care appointments. The program then follows babies through their first year, to ensure continuity of care and provide additional support.

"This program bridges the gap between what happens for these women at home and the medical care we provide," Plager says. "We have to recognize that a lot of the issues affecting this population are social, rather than purely medical." ■

8-3

STATE OF KANSAS

DOUG WALKER
SENATOR, 12TH DISTRICT
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MINORITY SUBCOMMITTEE REPORT
SB 521

It is the view of the minority members of the subcommittee on SB 521 that the substitute bill is inappropriate for the following reasons:

1. The substance of SB 521 was never seriously considered by the committee. After the testimony of a single conferee -- with a number of conferees waiting to testify -- this committee decided that the bill is dead and, in its place, a substitute bill or a totally new bill should replace it. The issue of a health care purchasing pool and the establishment of another legislative health care oversight committee are only remotely related. The full committee should allow all conferees to testify on SB 521 and then work the bill like any other proposal. To kill the bill after one conferee has testified with others waiting to speak seems inconsiderate at best. Usually we have the courtesy of hearing testimony before we kill bills, not afterward.

2. The joint committee on health care decisions for the '90s has the authority to do exactly what this new oversight committee is charged with. The only significant difference in the two committees is that one consists of an equal number of Democrats and Republicans and the proposed committee eliminates Democrat representation on the committee. To the charge that the composition of the joint committee did not lend itself to a serious discussion of health care reform is a smoke screen of gigantic proportions used only to blur the real issues. The joint committee's agenda is set by the chairman of the committee. Had the chairman of that committee been committed to serious health care reform efforts we would have addressed health care reform.

3. Another legislative health care reform oversight committee cannot -- will not -- address reform implementation details such as interagency agreements, implementation of specific cost control measures, specific capitation, fee-for-service arrangements and the multitude of other minute details of integrating the federal health care plan into the Kansas health care system or, absent a federal plan, develop a Kansas specific health care plan and the specifics for implementation.

To delay the establishment of some entity to coordinate the actual implementation of health care reform needlessly but effectively stalls any reform effort.

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9