Approved: March 31, 2011
Date

MINUTES OF THE HOUSE VISION 2020 COMMITTEE

The meeting was called to order by Chairman Tom Sloan at 3:30 p.m. on March 14, 2011, in Room 144-S of the Capitol.

All members were present except:
Representative Brett Hildabrand- excused
Representative Don Hill- excused
Representative Don Hineman- excused
Representative Mike Peterson- excused

Committee staff present:
Corey Carnahan, Kansas Legislative Research Department
Jay Hall, Kansas Legislative Research Department
Mary Koles, Committee Assistant

Conferees appearing before the Committee:
John M. Armstrong, Ph.D., Lead Horse Technologies, Junction City, Kansas
Dr. Andrew Allison, Kansas Health Policy Authority

Others attending:
See attached list.

Chairman Sloan welcomed and introduced today's presenters.

John M. Armstrong, Co-Founder, Chairman and CEO, Lead Horse Technologies, Junction City, Kansas, provided a Power Point presentation. He described his company as one that supports the practice of personalized medicine and works to reduce the rates, severity, and costs associated with Adverse Drug Reactions (ADRs). He reported that ADRs cost over 30 billion dollars/year, or 5.6 million dollars/year/hospital to treat, furthermore, 100,000 deaths occur in the United States each year due to preventable ADRs. Medloom Clinical Decision Support system is Lead Horse Technologies' software solution designed to save lives.

Dr. Armstrong described Medloom as a medical information loom that interweaves a variety of patient medical profile parameters and many drug safety databases to discover, prevent, and treat ADRs. It is effective, fast, easy to use (is compatible with existing electronic health record systems), protected by three patents, and has won a number of awards. Medloom's artificial intelligence technology also identifies patients at risk for death or hospitalization; discoverable information is quickly delivered to the point of care and helps clinicians prevent adverse outcomes. Medloom, he said, will help reduce healthcare costs for patients, providers, and payers and will create 100 jobs in Junction City, jobs with an average salary of $75,000. (Attachment 1)

During and following Dr. Armstrong's remarks, questions were asked by Representatives Bill Otto, Gail Finney, and Barbara Bollier - discussions ensued and included other committee members.

Dr. Andrew Allison, Executive Director, Kansas Health Policy Authority, examined implementing a medical home in Kansas Medicaid. He mentioned that three state agencies handle the majority of Kansas' Medicaid program: Department on Aging, Social and Rehabilitation Services, and the Health Policy Authority. Using graphs, he traced the growth in Medicaid spending nationally and the historical, recent, trends, and projected growth in Medicaid spending in Kansas. Graphs and charts depicted chronic conditions among and expenditures for an ever increasing number of disabled recipients. He discussed several cost containment options such as coordinating care across multiple conditions and services – e.g. implement a medical home for high-cost populations. He noted that dealing with federal health reform eventualities will be a huge challenge.

Dr. Allison explained implementing a medical home in Kansas Medicaid as a stakeholder driven process and delineated benchmarks along the way: passage of Senate Bill 81 in 2008 and subsequent development of the Kansas definition of a medical home: inclusion of the medical home initiative in the Kansas health information technology initiative (HIT) in 2009: and the outset of the Kansas Health Information

The minutes of the Vision 2020 Committee 3:30 p.m. on March 14, 2011, in Room 144-S of the Capitol.

Exchange Board (KHIE) in 2010. The health information exchange will facilitate implementation of a medical home for patients and patient centered care for each individual. (Attachment 2)

Following Dr. Allison's remarks, questions were asked by Chairman Sloan and Representatives Gail Finney, Vern Swanson, Barbara Bollier, and Joseph Scapa. Dr. Allison's responses initiated further discussions and comments or brief questions from other Committee members.

Chairman Sloan thanked the conferees for their presentations.

Chairman Sloan reported that Vision 2020's work in the telehealth field last year is paying off. Last week, he met with the Adjutant General, Brigadier General Lee Tafenelli, and William Patterson, MD, Director of Veterans Affairs Heartland Network (Region 15) health services. The VA Heartland Network and KU Medical Center are now partnered and providing telehealth/mental health services in three remote Kansas sites. This need will increase as more troops return home and include physical health as well as mental health.

Chairman Sloan thanked the Committee for its work this year and announced that no further meetings are scheduled until January, 2012.

The meeting was adjourned at 4:45 p.m.

Guest List

House Vision 2020 Committee

Monday, March 14, 2011

Name	Client/Authority
Leigh Keck	Capitol Strategies
Barb Langvardt	KCHPA
Andy Allison	KHPA
Dustin Meyer	
Megan Brooks	Legislative Intern - Rep. Don Hill
Lindsay Thornton	Kansas Bioscience Authority

LEAD HORSE TECHNOLOGIES, INC.
LEADING THE WAY.

Lead Horse Technologies makes software that is designed to save lives.

Too often patients experience unexpected side effects when taking medications. These adverse drug events, or "ADRs" as they are known, can be inconvenient, like a rash, or they can be life-threatening, like a heart attack or stroke. Sadly, it has been estimated that the number of people who die each year in the U.S. from ADRs is equivalent to a jumbo jet crashing and killing everyone aboard EVERY SINGLE DAY OF THE YEAR. These deaths are due to medications that should be helping people, not hurting them. The answer is not to stop prescribing the drugs that treat and cure diseases, but to provide doctors, nurses, and pharmacists with the information they need about ADRs *at the time they need it* to see that medications are used as safely as possible.

Drug safety information is important for many components of our healthcare system, including pharmacies, hospitals, health insurance organizations, pharmaceutical companies and others. It's been estimated that the cost to hospitals alone of treating preventable ADRs is as much as $30B per year in the U.S., and that is in spite of the commercial availability of drug-drug interaction and adverse event information from providers of electronic medical records

Lead Horse Technologies, Inc., Liberty Hall, 4718 Liberty Hall Road, Jur
P: (785) 238-LOOM (5666); F: (785) 223-LOOM; www.leadhors

and clinical decision support (CDS) systems. Something more is needed, and that's why Kansas-based Lead Horse Technologies built the Medloom™ CDS system.

Recognizing that many ADRs occur in patients with complex polypharmacy (multi-drug) profiles and with different ages, genders, background conditions and symptoms, and other distinctions that make us all unique, Lead Horse Technologies built a software solution called Medloom so that we could 'stop the jet from crashing.'

Many different balls of wool can be plugged into an ordinary loom in order to weave a tapestry; likewise, the Medloom CDS system is built as a medical information loom to weave together a variety of patient medical profile parameters and many disparately structured drug safety databases toward the discovery, prevention, and treatment of ADRs. What Medloom does not allow is the integration of any patient's identity; for that matter, nor does it ever collect a clinician's identity, which makes Medloom the only safe harbor in the U.S. where adverse event queries can be made by a clinician. Use of Medloom is made easy by integration within the health organization's existing information technology system. In fact, there is no technology barrier to overcome: Medloom provides information within the look and feel of the software system currently in use by the healthcare professional. In addition, Medloom-based improvements in clinical outcomes are tied to improvements in health economic impact, so not only can lives be saved, but improvements in patient safety can be monetized for real-time monitoring of dollar ROI after integration.

We're proud to have created this important health IT technology, and we look forward to counting the lives it saves and the hospitalizations it prevents. Importantly, Medloom-empowered Health IT systems will have a competitive edge in driving down the costs of healthcare for all stakeholders, including the patient, the provider, and the payer.

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Medloom™ as a 'bolt-on' to any electronic health information system

Lead Horse Technologies is a personalized medicine company that sells the **Medloom** Clinical Decision Support (CDS) system as a cloud-based application in a pure Software-as-a-Service (SaaS) model to help healthcare provider and payer organizations reduce the costs associated with adverse drug reactions (ADRs). Medloom applies artificial intelligence-driven, pattern recognition technology to its database of millions of individual case reports obtained from the FDA's MedWatch system to discover statistically significant associations relating drugs to ADRs, and then, through an interface to an electronic health information system (electronic medical record (EMR) systems, Claims databases, etc.), identifies patients potentially at risk for those ADRs. Neither the patient nor the clinician is identified with the Medloom CDS system. The cost-savings are metricked for demonstrable ROI. Current CDS systems often fail to address drug-disease interactions, do not incorporate patient symptomology and real-world drug safety surveillance data, and cannot screen a patient database to prevent ADRs. The Medloom CDS offers a transformative solution to the unmet medical need for rapid access to ADR information at the point-of-care.

Medloom is centralized and hosted by Rackspace at its Dallas, Texas facility, though fail-over and mirror systems are planned for multiple locations. Through monthly hosting fees (12-month minimum license agreements), Lead Horse provides access to Medloom in a cloud-based SaaS model through web services, HL-7, CCD, or any protocol required by its customers. Implementation at each customer site will require custom integration (once for each major EMR provider, e.g., EPIC, Cerner, McKesson, etc.), followed by quick, repeat integrations at satellite customer sites using Lead Horse personnel to provide a hassle-free process wherein Lead Horse is the flexible partner in the process. No physical transfer of product is required except the transfer of information over the internet, therefore production costs are negligible.

Lead Horse Technologies, Inc., Liberty Hall, 4718 Liberty Hall Road, Junction City, KS 66441
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MEDLOOM
DECISION SUPPORT SYSTEM

Using Medloom to Save Lives,
Save Money, and Grow Jobs in Kansas

John M. Armstrong, Ph.D., CEO; Ramie Leibnitz, Ph.D., President
Lead Horse Technologies, Inc.

Vision 20/20 MARCH 14, 2011

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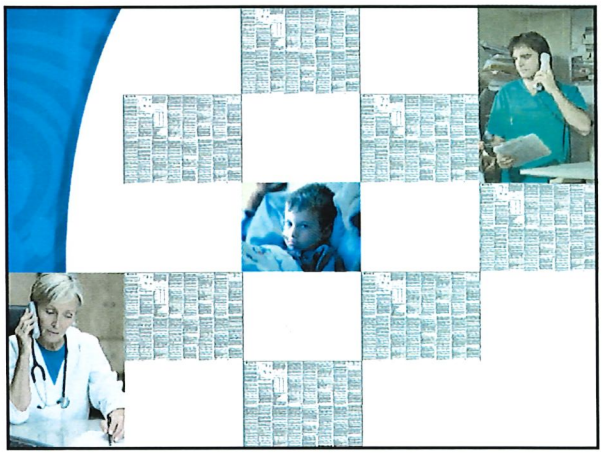

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The size of the problem in the U.S. alone.

Lives lost everyday to preventable drug safety issues.
$30B/yr of expense for hospitals alone.
Better, earlier information is needed.

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Our Solution

- Effective
  - Built to stop the jet from crashing
  - Billy's case is solved in 20 sec.
- Fast
  - Healthcare Search Engine
  - World's fastest database
- Easy to use
  - Bolts onto any, existing electronic health record system
- Protected
  - Three patents pending in nations around the world
- Award-winning

MEDLOOM
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Our Awards and Honors

- InterSystems 'Innovator of the Year', #1 in Healthcare, globally
- InterSystems becomes Lead Horse's 'Global Technology Partner'
- Gartner Health IT Summit's 'Best Case Study' (Beat Microsoft & ICA)
- Finalist, 'Best New Technology', Providers
- Finalist, 'Best Case Study', Providers
- Finalist, 'Solution with the Greatest Market Potential', Providers

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Our Solution

Medloom's new artificial intelligence technology

- Identifies patients at risk for death or hospitalization
- Helps clinicians prevent these events from occurring

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Case Study Demonstration

MedWatch The FDA Safety Information and Adverse Event Reporting Program

February 4, 2011

AVANDIA: Risk of Cardiovascular Events, including Heart Attack

[UPDATED 02/04/2011] FDA notified healthcare professionals and patients that information on the cardiovascular risks (including heart attack) of rosiglitazone has been added to the physician labeling and patient Medication Guide. This information was first announced by FDA on September 23, 2010 as part of new restrictions for prescribing and use of this drug.

Rosiglitazone is sold as a single-ingredient product under the brand name Avandia. Rosiglitazone is also sold as a combination product under the brand name Avandamet (contains rosiglitazone and metformin) and under the brand name Avandaryl (contains rosiglitazone and glimepiride).

Summer 2007

AVANDIA: WARNING!
Risk OF Heart Attack or Unstable Angina
In combination with ASPIRIN, ATENOLOL, FUROSEMIDE, & SIMVASTATIN
Confidence of Association = 83.33%

Pop Quiz:

How many lives could have been saved if this information had been provided to clinicians when it was first detectable?

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Case Study Demonstration

Bloomberg

February 7, 2011

Glaxo Said to Pay More Than $250 Million to Settle 5,500 Avandia Death Lawsuits

GlaxoSmithKline Plc agreed to pay more than $250 million to resolve about 5,500 claims related to its **Avandia** diabetes drug and avoid the first trial over claims it can kill users, two people familiar with the accords said.

Glaxo, the U.K.'s biggest drugmaker, agreed to settle the lawsuits claiming the drug causes heart attacks and strokes for an average of at least $46,000 each, said the people, who declined to be identified because they weren't authorized to speak publicly.

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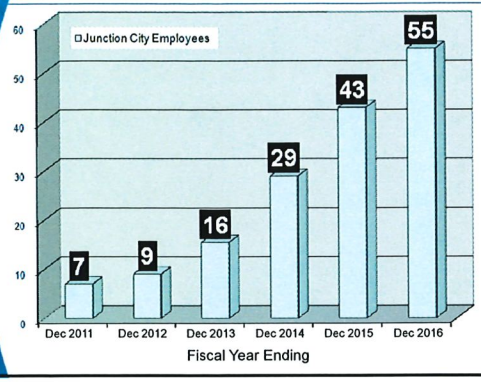
Growing Jobs in Kansas



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Visualize Success

Success in Kansas

Date:	Dec. 31, 2011
Lives saved by Medloom:	1,000
Costs Lowered ($):	22,500,000

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Using Medloom to Save Lives,
Save Money, and Grow Jobs in Kansas

Questions?

(785) 238-5666
john@leadhorsetech.com; ramie@leadhorsetech.com

John M. Armstrong, Ph.D., CEO; Ramie Leibnitz, Ph.D., President
Lead Horse Technologies, Inc.

Vision 20/20 MARCH 14, 2011

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KANSAS HEALTH POLICY AUTHORITY

Implementing a Medical Home in Kansas Medicaid

Vision 2020 Committee

March 14, 2011

Dr. Andrew Allison, KHPA Executive Director

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Overview

- The Medicaid quality and sustainability crisis
- Medicaid cost containment efforts — remaking the program
- Implementing a Medical home in Kansas Medicaid

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The New Economy

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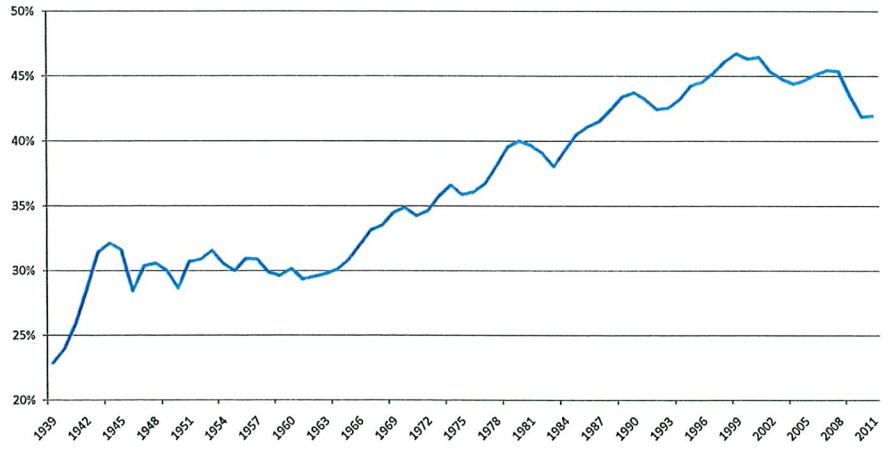
Fundamental Shifts in the US Economy

Percentage of US Population with Non-Farm Employment

Sources: Current Employment Statistics Survey, BLS; US Bureau of the Census



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Impact of the New Economy on State Budgets

- States across the country are facing enormous deficits
- Possibility of credit default and "bankruptcy" is receiving serious consideration in economic policy circles
- Future economic growth is uncertain
  - Many project slow growth at the national level
  - State efforts could enhance the Kansas economy
- Projections of state deficits in Kansas range into the hundreds of millions as soon as FY 2013
- Will Medicaid costs continue to drive state spending and exacerbate deficits?

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Growth in Medicaid Spending Nationally

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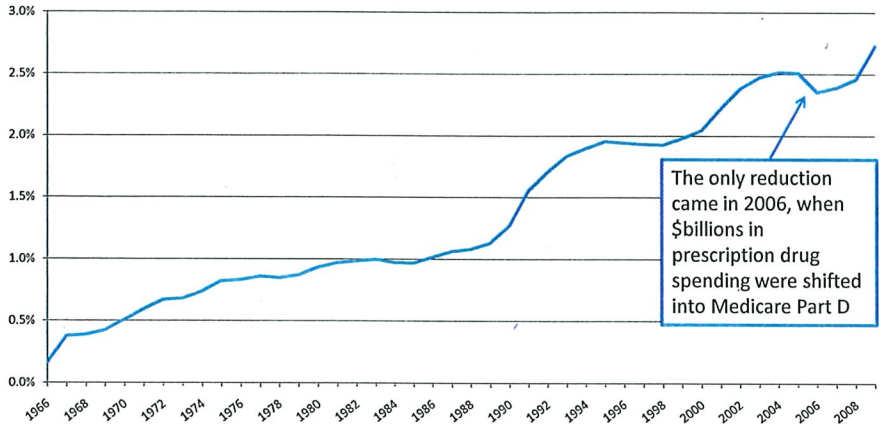
Medicaid's Growth Outpaces the National Economy

Total Medicaid and CHIP Spending as a Percentage of GDP

Sources: National Health Accounts, US DHHS; US National Product and Income Accounts, BEA



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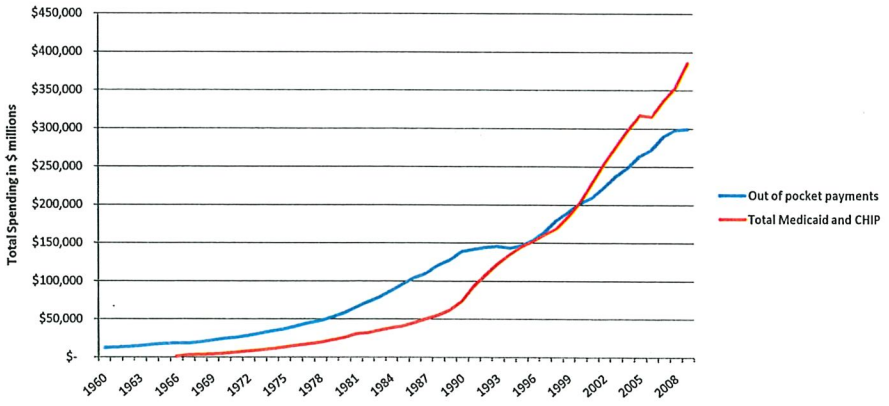
Medicaid's Growth Outpaces Individual Spending

Medicaid Spending vs. Total Out-of-Pocket Payments by Individuals

Source: National Health Accounts, US DHHS



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Growth in Medicaid Spending in Kansas

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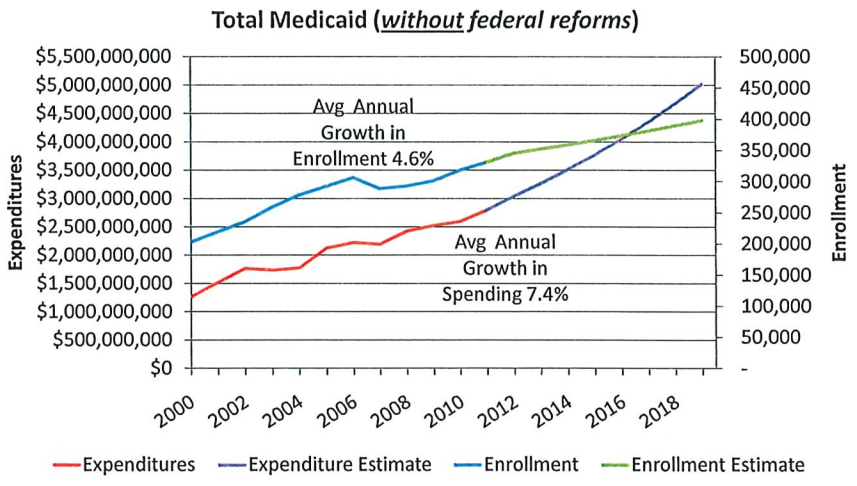
Potential Growth in Kansas Medicaid*



*Preliminary estimates. New projections will follow consensus caseload process in April 2011.

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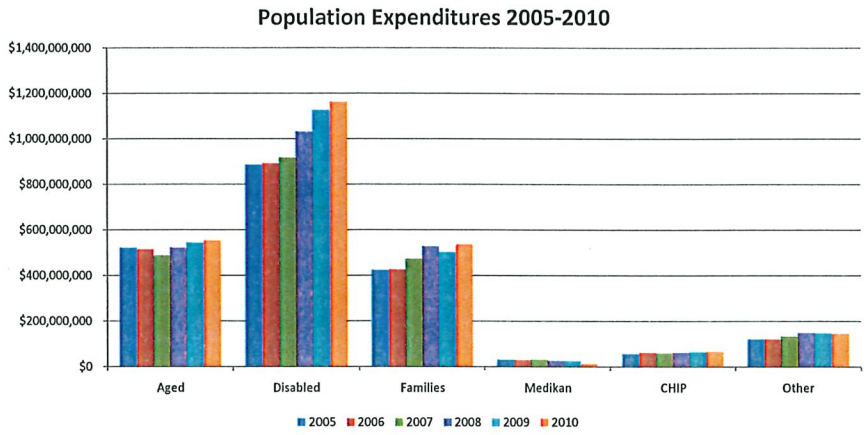
Recent Growth in Spending by Population



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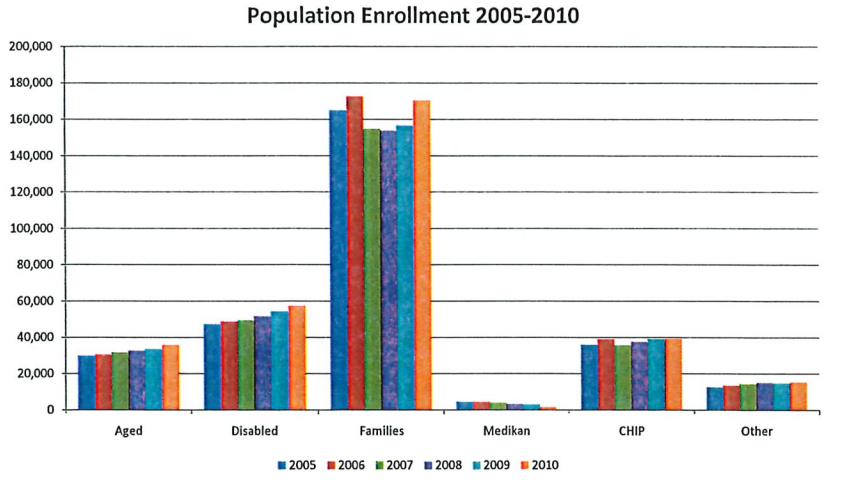
Recent Growth in Enrollment



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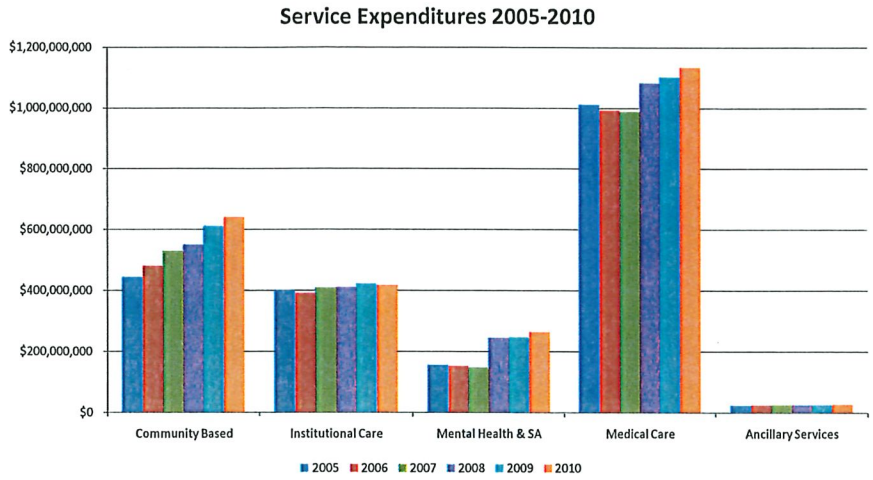
Recent Growth in Spending by Type of Service



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Concentrations of Program Dollars Across Populations and Services

Population

Service: Total Spending (SFY 10; $ millions)	XXI-Children in CHIP	XIX-Adults and children	Disabled	Elderly	Other & MediKan	Total
Physical health	61	494	450	107	76	1,187
Behavioral health	4	33	102	12	32	184
Substance abuse	NA	8	7	0	7	22
Nursing facilities	NA	0	111	312	1	424
HCBS	NA	NA	479	121	8	608
Total	65	535	1,149	552	124	2,425

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Existing Silos in Medicaid Service Delivery

Population

Service: Purchasing Program	XXI-Children in CHIP	XIX-Adults and children	Disabled	Elderly	Other & MediKan	Managing Agency
Physical health	HealthWave MCOs	HealthWave MCOs; HealthConnect PCCM	HealthConnect PCCM and FFS	FFS	FFS	KHPA
Behavioral health	CHIP MCO	PAHP	PAHP	PAHP	PAHP	SRS, KHPA
Substance abuse	CHIP MCO	PIHP	PIHP	PIHP	PIHP	SRS, KHPA
Nursing facilities	N/A	FFS	FFS	FFS	FFS	SRS, KDOA
HCBS	N/A	N/A	PD, DD, TBI, SED, TA, Autism, and CBA waivers	FE waiver	TA,DD waivers	SRS, KDOA

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Trends in State Medicaid Spending

- Long-run trends in Medicaid spending are driven by widespread increases in enrollment and spending per person
- Most spending, and most of the growth in Medicaid spending, is attributable to the aged and disabled populations
- The Medicaid cost crisis cannot be addressed without reducing growth in spending across all Medicaid populations, but especially among the disabled
- The state is in the midst of a sustained period of accelerated growth in the number of newly-disabled recipients as baby boomers reach the age of onset of acquired disability
- Medicaid spending is spread widely across service types, funding streams, and state agencies – often for the same population

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A Focus on the Disabled Population

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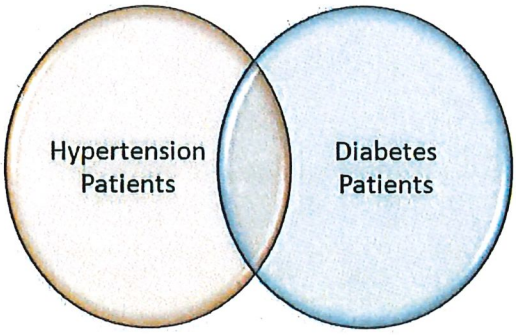
A Picture of Chronic Conditions Among Disabled Recipients

Hypertension and Diabetes Patients



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Chronic Conditions Among Disabled Recipients

SSI Disabled Hypertension Patients Expenditure by Episodes of Care

Episode of Care	FY 07 Expenditure	FY 08 Expenditure	FY 09 Expenditure
*Mental Health	$ 19,470,626.53	$ 10,545,687.92	$ 6,858,631.14
Diabetes	$ 8,933,706.96	$ 10,459,032.98	$ 9,670,361.45
Mental Hlth - Schizophrenia	$ 10,451,819.31	$ 6,997,382.24	$ 6,858,631.14
Hypertension, Essential	$ 8,277,959.76	$ 7,269,614.69	$ 7,160,513.93
Pneumonia, Bacterial	$ 4,505,617.72	$ 5,807,120.88	$ 6,002,822.42
Coronary Artery Disease	$ 5,208,510.50	$ 5,407,204.51	$ 5,417,332.81
Condition Rel to Tx - Med/Surg	$ 4,547,452.49	$ 3,898,230.61	$ 3,579,839.59
Renal Function Failure	$ 3,572,006.44	$ 3,804,726.71	$ 3,977,878.37
Osteoarthritis	$ 3,379,792.86	$ 3,822,380.31	$ 3,690,618.09
Infec/Inflam - Skin/Subcu Tiss		$ 5,681,519.28	$ 4,869,995.61
Mental Hlth - Depression	$ 3,552,531.06	$ 3,548,305.68	
Mental Hlth - Bipolar Disorder	$ 5,466,276.16		
Cerebrovascular Disease			$ 3,699,274.31
Total Expenditure	$ 57,895,673.26	$ 56,695,517.89	$ 54,927,267.72
Total SSI Population Expenditure	$ 286,412,407.71	$ 306,144,449.37	$ 321,739,482.70
Hypertension Patients Percentage of SSI Total Expenditure	20.2%	18.5%	17.1%

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Chronic Conditions Among Disabled Recipients

SSI Disabled Diabetes Patients Expenditure by Episodes of Care

Episode of Care	FY 07 Expenditure	FY 08 Expenditure	FY 09 Expenditure
*Mental Health	$ 14,461,090.60	$ 10,650,256.31	$ 4,917,227.58
Diabetes	$ 15,758,609.36	$ 18,078,677.22	$ 17,599,448.54
Mental Hlth - Schizophrenia	$ 7,910,255.11	$ 5,147,486.72	$ 4,917,227.58
Infec/Inflam - Skin/Subcu Tiss	$ 4,089,968.31	$ 5,703,397.89	$ 4,364,837.17
Pneumonia, Bacterial	$ 4,106,881.89	$ 4,293,006.98	$ 4,156,101.39
Coronary Artery Disease	$ 4,127,257.39	$ 3,752,721.62	$ 4,138,178.87
Hypertension, Essential	$ 3,678,536.60	$ 2,828,879.71	$ 3,185,540.33
Condition Rel to Tx - Med/Surg	$ 3,115,907.88	$ 2,990,364.12	$ 3,353,517.37
Renal Function Failure	$ 2,652,392.87	$ 2,422,917.42	$ 2,474,299.74
Mental Hlth - Bipolar Disorder	$ 3,776,999.09	$ 2,688,455.65	
Mental Hlth - Depression	$ 2,773,836.40	$ 2,814,313.94	
Chronic Obstruc Pulm Dis(COPD)			$ 2,157,424.34
Osteoarthritis			$ 2,050,514.94
Total Expenditure	$ 51,990,644.90	$ 50,720,221.27	$ 48,397,090.27
Total SSI Population Expenditure	$ 286,412,407.71	$ 306,144,449.37	$ 321,739,482.70
Diabetes Patients Percentage of SSI Total Expenditure	18.2%	16.6%	15.0%

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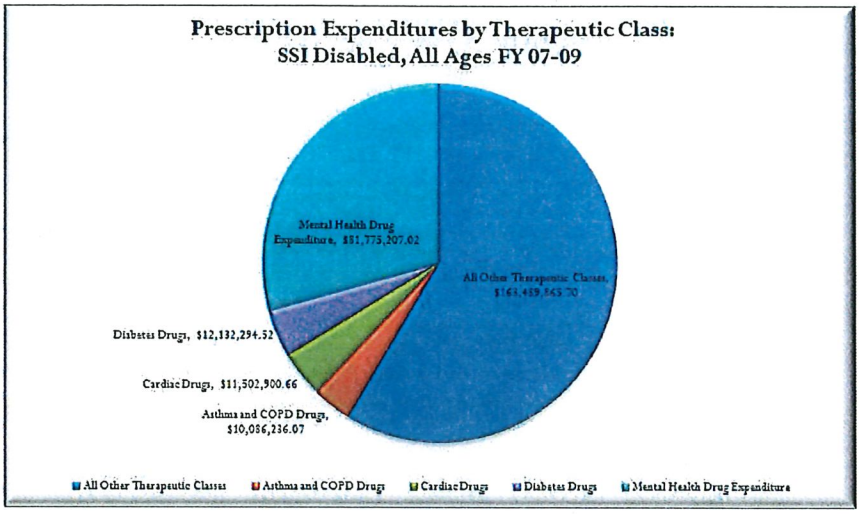
Chronic Conditions Among Disabled Recipients



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Explaining Cost Growth Among Disabled Recipients

- Growth is comprised of spending across multiple chronic conditions
- Spending is concentrated in chronic conditions that extend far beyond the proximate disability
- Kansas' ongoing efforts to implement a medical home, coordinating care in a holistic fashion, appear to be steps in the right direction
- Much remains to be learned about the underlying causes of growth in spending

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Medicaid Cost Containment — Remaking the Program

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Medicaid Cost Containment: Options

<u>Avoiding unnecessary spending</u>

- Available approaches to reduce Medicaid spending
  - Reduce payments
  - Reduce eligibility
  - Reduce range of services offered
  - Lower utilization through appropriate management and improved services
- Limitations on state flexibility
  - Eligibility maintenance of effort (MOE) requirement began in ARRA and was made permanent in the ACA
  - Potential legal restrictions on state flexibility to reduce payments
  - Vast majority of optional spending is for services that either improve health , lower overall costs, or could be protected by the MOE
- Remaining options are to redesign program payments, coordinate care, address unnecessary utilization and ensure positive incentives for both consumers and providers to achieve high quality care

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Medicaid Cost Containment: Keys to Success

- Recognizing the need for change
- Understanding the cost drivers and potential solutions
- Political ownership of the program and its challenges
- Strong leadership and a sustained effort
- Active engagement with Kansas health care community
- Coordinating care across multiple conditions and services
  - e.g., implement a medical home for high-cost populations
- Timely action and fundamental changes

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Medicaid Reform Process: Emerging Objectives

- Focus the program on the whole patient and eliminate silos in care and oversight
- Increased focus on quality and measurement of outcomes
- Recognize the role of Medicaid in the marketplace, and restore market forces to Medicaid
- Lower the overall cost of health care and Medicaid
- Deal with the contingencies of federal health reform
- Move quickly, but focus on changes over the long run

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Implementing a Medical Home in Kansas Medicaid

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Defining Medical Home in Kansas

- Stakeholder driven process
- Began in 2007 and occurred during 2008 Legislative Session
- Culminated with the passage of Senate Bill 81
  - Codified the definition of medical home in statute
  - Directed KHPA to establish a medical home delivery model for Medicaid, CHIP, and State Employees Health Plan
  - Directed the agency to develop systems and standards for implementing medical home model of care

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Kansas Medical Home Definition

- As stated in the statute, the Kansas definition of a medical home is "a health care delivery model in which a patient establishes an ongoing relationship with a physician or other personal care provider in a physician-directed team, to provide comprehensive, accessible and continuous evidence-based primary and preventive care, and to coordinate the patient's health care needs across the health care system in order to improve quality and health outcomes in a cost effective manner."

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Medical Home Stakeholder Group

- Medical Home Stakeholder Group met from summer 2008 through early 2009
  - Marketing and Communication Subgroup
  - Guiding Principles Subgroup
  - Pilot Project Subgroup
- March 2009 Kansas Medical Home Initiative was folded into the statewide health information technology (HIT) initiative
  - Information is key to the coordination of care required in a medical home

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Statewide HIT/HIE Efforts

- Kansas Health Information Exchange (KHIE) Board is meeting regularly and beginning to address core strategic and policy issues
- KHPA is finalizing a contract with an outside vendor to write the State Medicaid HIT Plan (SMHP) for submission to HHS later this year
- KHPA is working towards implementation of a process to support Federal Medicaid incentive payments to providers meeting Medicaid Stage 1 meaningful use requirements – target is late summer

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Kansas Medicaid HIE Goals

- Utilize the HIE to measure meaningful use
- Utilize the HIE to gather data needed to document and measure qualification for Medicaid incentive payments
- Utilize the HIE as needed to gather data and fill gaps in order to compute quality measures, and to help manage and coordinate care to ensure meaningful use for beneficiaries – regardless of their connection to a primary care medical home
- Utilize the HIE to facilitate a medical home and patient centered care for each individual

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