TESTIMONY TO THE KANSAS SENATE PUBLIC HEALTH & WELFARE COMMITTEE

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Good afternoon. My name is Kevin Miller and I serve as the President and CEO of Hutchinson Regional Healthcare System. It is my pleasure and honor to be able to testify before you today regarding Medicaid Managed Care.

Before I delve into the subject, I would like to familiarize you with the relevant aspects of Hutchinson Regional Healthcare System as well as my background.

Hutchinson Regional Healthcare System is comprised of a 199-bed non-profit acute-care regional medical center (Hutchinson Regional Medical Center); a community mental health agency serving 5 counties (Horizons Mental Health Center); a 80+ bed long-term care facility (Ray E. Dillon Living Center); a hospice and a home health agency (Hospice and Home Care of Reno County); and a for-profit durable medical equipment and supply company (Health-E-Quip). Our hospital provides almost 25,000 ER visits annually and we operate the EMS service in Reno County.

I arrived in Reno County, Kansas, in July of 2011 after having served Cleveland Clinic as President/CEO of Ashtabula County Medical Center and ACMC Healthcare System near Cleveland, Ohio, for the last 8+ years.

During my tenure in Ohio, I was very actively engaged in representing my organization to the Ohio legislature and the state agency responsible for Medicaid services after Ohio implemented a Medicaid MCO program. Specifically, I worked closely with State Senator Capri Cafaro in an effort to resolve many and various issues negatively impacting Medicaid recipients and their providers (physicians and hospitals) resulting from a poorly planned program.

I do understand and support the need for a Medicaid managed care program in Kansas. The State cannot continue to see large increases in spending associated with this program. That is clear. It is my goal, however, to point out the errors made by Ohio so that we may learn from those mistakes.

I concur with KHA's position contained within five specific domains: access to care; delivery system reform; care management; provider reimbursement; and issues related to the hospital provider assessment program.

The majority of mistakes in Ohio specifically centered around issues of access to care for this population in a timely and ethical manner. The state created a model which emulated an HMO model. The state

was divided into a few regions and the state competitively bid the contracts and awarded contracts to at least 2 private insurers for each region. The **insurer**s were, basically, told that they had a bucket of money from the state from which they must provide services and create any profit, if any. The devil was in the details. Insurers were not required to create any drug formularies. Instead, physicians and their staffs were required to call the insurance company to obtain prior authorization for any and all prescriptions, home medical equipment, inpatient and outpatient hospital services, etc. Obviously, this was a very high volume of calls each day for the physicians' office staffs. A majority of the insurers, purposefully in my opinion, did not adequately staff their prior authorization departments. Therefore, physicians' staff would be kept on hold for a range of time which, at times, exceeded 2 hours. As you might expect, the office staff would, oftentimes, become frustrated and hang up without ever speaking to anyone. Again, in my opinion, this is exactly what the insurer hoped would be the case so that they could increase the chances of profitability.

As a result, patients did not receive the care, equipment and/or medication which they needed. They, as a group, became more acutely ill, which then required more resources to treat them. Most hospitals saw large increases in their Medicaid ER visits because of the inability of the physicians to adequately treat them in the office setting.

Many physicians became quickly frustrated and limited or eliminated their Medicaid office practice.

These same insurers further reduced Medicaid reimbursement to providers. Payment of claims **were** was further slowed down as well.

On the insurer side, most found their contracts to be less than rewarding and we routinely saw a revolving door of insurers in the various regions.

After approximately 2-3 years, the insurers finally began to develop and allow drug formularies so that the volume of prior authorization calls significantly declined. But, inadequate access to care remained an issue throughout my tenure in Ohio.

Earlier, I briefly discussed Medicaid recipients utilization of the ER for routine primary care services. I would like to relay one specific Ohio example to you. "John" was a homeless individual in our community of 20,000 people. He was a Medicaid recipient and suffered from chronic substance abuse and mental illness. "John" came to my ER over 250 times in a 12 month period for abdominal pain. At first, we thought he was a seeker of pain meds, but this turned out to be inaccurate. The ER physicians would give him some over-the-counter medication or non-narcotic prescription medication and he would be satisfied. When I asked why the ER staff simply didn't turn him away after a medical screening determined that his condition was non-emergent, I was told that it was for 2 reasons. The ER physicians feared being sued if something subsequently occurred after they turned him away. The second reason was because of his out-of-control outbursts in the ER when they had previously tried to get him to leave.

Recommendations:

1. I encourage the state to develop Medicaid policies which result in appropriate utilization of health care services, **i**.**e**., ER services.
2. As KanCare is developed, require the insurers to adopt uniform authorization policies/procedures for access and reimbursement.

3. Ensure that insurers will not inappropriately limit access to this population. One suggestion is that they must develop comprehensive drug formularies, which do not require prior authorization, and require them to respond to all prior authorization calls from hospitals and physicians' offices within a defined period of time.
4. Require speedy payment of "clean" claims by insurers.
5. Seriously consider the recommendations made by KHA in the 5 specific domains.
6. Do not further reduce Medicaid reimbursement to providers.

Thank you.