KANSAS MEDICAL SOCIETY
Established 1859

To: Senate Public Health and Welfare Committee

From: Jerry Slaughter
Executive Director

Date: January 17, 2012

Subject: KanCare; Medicaid Reform

The Kansas Medical Society appreciates the opportunity to appear today to share our thoughts on Medicaid reform and the Brownback administration's plan to significantly expand the use of managed care, and in particular, for the first time to cover the aged, blind and disabled populations within a managed care environment.

KMS is a statewide association which represents nearly 4600 physicians in all medical specialties. While health care is a team effort, physicians represent the backbone of our health care system, and for any systemic reform of Medicaid to be successful, we must engage the physician community to become active partners in the process. We have a long history of actively encouraging physicians to participate in the Medicaid program, to ensure that our state's most vulnerable citizens have access to essentially the same network of medical professionals that serves the private insurance markets. Historically, about nine out of every ten physicians has participated in Kansas Medicaid.

We are encouraging our members to continue their commitment to this important public program that serves nearly 350,000 Kansans. Yes, Medicaid will be different than the program which health care providers have known for the past generation. It will ask more of every health care professional as it attempts to improve outcomes and slow the growth of costs. The physician community understands the seriousness of the financial challenges facing our state, and that there are no easy decisions for policymakers when it comes to balancing the needs of the state with the resources which are available.

Against a backdrop of declining federal revenues and a slowly recovering economy, Governor Brownback and his team have proposed an ambitious approach that will rely on the potential of better care coordination and reduced program fragmentation to ensure the long term sustainability of Medicaid though improved health outcomes, slower growth in costs, preservation of eligibility, and avoidance of provider cuts. This approach is recognition that the notion of just continuing to do Medicaid as we always have done it, in the context of today's fiscal challenges, is just a non-starter.

That is not to say that we don't have some questions and concerns about the capacity of managed care companies to absorb the care coordination responsibilities of populations

with special needs and chronic, disabling conditions so quickly. Although the contracts for the three KanCare managed care organizations that will be selected don't begin until January 1, 2013, that is still a pretty aggressive timeline to meet, given all that is being asked of the MCOs and the providers within their networks.

We know there is skepticism about expanding the reach of MCOs to Medicaid populations such as the aged and developmentally disabled, populations that have thus far been outside the traditional managed care systems. There isn't anything magic about the managed care model. It is just hard work, taking accountability for outcomes, paying attention to detail, and making sure that the right care and services are provided at the right time in the right setting. Almost all health care providers have over the years experienced a number of variations of managed care, both in private and public programs. Some are better than others.

However, managed care does give the state the ability to predict, and fix, its costs in the program with some certainty. But more importantly, it gives the state the opportunity to improve care outcomes by better integrating physical health care with social and support services, and aligning incentives properly among MCOs, the provider community, and the individuals and families that are being served. As you know, the RFP outlines some pretty specific quality and outcomes benchmarks that will require everyone involved to work together towards a common set of goals. It also incorporates the patient-centered medical home concept, which holds a great deal of promise to improve care and more effectively allocate resources. Although what has been proposed does represent significant change for many in the program, it also represents an opportunity to serve the needs of individuals and families better.

In fact, the program that is envisioned by the administration is really more about better care coordination, rather than care management. For the purposes of KanCare, the companies selected are really going to function more as coordinated care organizations, rather than managed care organizations. For them to achieve what is desired for the program, it will require them to engage the provider and service communities in a much more collaborative and coordinated environment than we have had in the past. If they are able to improve communication and coordination among care providers, improve care transitions, reduce duplication of services, and eliminate fragmentation (and the care "silos" that are so prevalent today), then not only will outcomes improve, but it will begin to slow the growth in spending.

In designing this program during the past year, the administration took great pains to reach out to all stakeholders. In fact, the process of stakeholder engagement that has taken place in the development of this program is unlike any we have ever seen in our Medicaid program. It has been an open, inclusive process, and the administration welcomed input from all who were interested. We, like a number of organizations, made

several specific recommendations, including establishing a stakeholder advisory committee to help improve communication and assist with policy development, especially during the transition year to the new program. We also encouraged the administration to standardize administrative functions, including prior authorizations, care transitions, medical policies and procedures, credentialing and appeals. We also encouraged the administration to identify and eliminate any burdensome and time consuming process requirements that don't appreciably improve value or outcomes, but which just add time and/or hassle to physician practices.

One of the most refreshing things about the approach that the administration took is that in reaching out to the provider community, it was clear that they wanted to engage providers as partners, not just vendors. The KanCare RFP is pretty clear that the MCOs are going to be required to be inclusive with their networks, and engage not only physicians, hospitals, and other traditional health care providers, but also community mental health centers, safety net clinics, centers for independent living, and community developmental disability organizations. In other words, the administration appears to be committed to this program being delivered in a coordinated environment among providers who collaborate to provide the best possible care, services and experience for the individuals and families that are served by the program.

The Kansas physician community recognizes that redesigning the Medicaid program won't be easy or without some bumps in the road. However, most realize that the state simply cannot continue to absorb increases in program expenditures which exceed 7% annually. As legislators responsible for appropriating the financial resources necessary to care for the Medicaid population, you understand that the status quo is unacceptable because it is unaffordable in the long run. KMS is committed to working with the legislature and the administration to help ensure that we have a patient-centered, high quality Medicaid program that is fiscally sound and sustainable.

Thank you for the opportunity to offer these comments.