TO: Senate Public Health and Welfare Committee

FROM: Tom Bell
President and CEO

DATE: January 17, 2012

RE: Medicaid Reform and the KanCare Program

On behalf on the 126 member institutions of the Kansas Hospital Association, we appreciate the opportunity to provide our perspective on the subject of Medicaid reform and the administration's proposed movement to the KanCare program.

Over the years, Kansas hospitals have worked in partnership with the state to insure that our most vulnerable and needy citizens have access to quality health care. Our commitment to that relationship and our willingness to be a partner with the state in the construction of a reformed Medicaid program remains strong. We recognize that the current trajectory for Medicaid expenditures are not reasonably feasible and that initiatives must be developed that will improve outcomes and reduce costs, especially those costs that result from excessive and redundant rules and regulations that have little correlation to quality care.

It is because of these issues that the KHA Board of Directors formed a special task force consisting of representatives of hospitals from each region of the state and from all sizes to identify a set of criteria that should be considered under a reformed Medicaid program. The task force identified five specific domains that impact hospitals: access to care; delivery system reform; care management; provider reimbursement; and issues related to the hospital provider assessment program.

Access to Care

1. Community hospitals are the ultimate safety net for the uninsured and Medicaid enrollees. Unfortunately, hospital emergency departments become the location of first choice to seek care regardless of the severity of the services being sought. Not only is the emergency department the most expensive setting for delivering care, it drains valuable resources from those truly in need of emergency services. In order to preserve the safety net for all citizens to receive emergency services when needed, the state should adopt Medicaid policies that encourage the appropriate utilization of health care services.

2. Better utilization of primary care providers across the state should be encouraged, incentivized, and supported. New initiatives to educate and inform enrollees on appropriate utilization of services should be a required element of continued eligibility of Medicaid recipients.

Delivery System Reforms

1. The State's Medicaid program should move toward rewarding clinical outcomes that improve quality and reduce costs in an organized and agreed upon process that involves key stakeholder participation. The state should recognize that the development and implementation of new and innovative quality and cost controlling programs are expensive and should be subsidized to encourage their development.

2. Care delivery infrastructures should be organized in such a way that encourages beneficiaries to seek care in the most appropriate setting, at the appropriate time and discourages the over utilization of unnecessary and inappropriate services.

3. Delivery system models that focus on population groups that consume a disproportionate share of the state's Medicaid resources should be a priority. Providers willing to work in partnership with the state in developing and implementing programs around these population groups should be encouraged and rewarded.

Care Management

1. Programs such as patient-centered medical homes, chronic disease management, and personal wellness should be encouraged, designed and developed. Incentive-based programs for willing enrollees and providers, including hospitals, should be tried to assess their ultimate effectiveness.

2. Expansion of the State's Medicaid Managed Care programs into populations that previously were not included should be approached in a very transparent and thorough manner. Any expansion of managed care into populations previously paid under fee-for-service has an impact on the State's Hospital Provider Assessment program and must be considered.

Provider Reimbursement

1. Hospitals and physicians that care for Medicaid enrollees should be paid fairly and adequately to ensure access to care is available in the right setting at the right time. Arbitrary reductions to payments to achieve short-term budget objectives only serve to make the program more costly to all Kansans in the long run, and create a distinct threat to continued access to services in our state.

2. Medicaid rules and regulations governing billing, payment, coding and audits should be examined and evaluated on how costly they are to administer and how effective they are at controlling costs. At a minimum, the State's Medicaid rules should be consistent with and aligned with Medicare so that providers don't have two sets of rules and regulations governing public programs. As examples, hospitals are subject to post-payment audits from the State's Medicaid Recovery Audit Contractor (HealthData Insights), the federal government's Medicaid Integrity Contractor (Health Integrity), and the State's Quality Improvement Organization and Medicaid utilization review contractor (Kansas Foundation for Medicare Care) who are all essentially examining the same records for the same things. The costs to providers to not only comply with but also manage within the rules and regulations of all of these diverse organizations are tremendous and must ultimately be passed on to other consumers.

Hospital Provider Assessment Program

1. The Hospital Provider Assessment Program passed by the Legislature in 2004 has been one of the state's most successful programs in ensuring that hospitals and physicians are paid adequately. Outside of this program, no incremental rate increases for per-item services have been provided to hospitals and physicians since the mid-1990s. The program generates over $80 million annually that would otherwise have to be generated out of state revenues. Any initiatives that would serve to endanger this program should be pursued cautiously and with consultation of the hospitals that pay the assessment.

Over the course of the past several months, KHA and its members have participated in the administration's Medicaid reform public input forums and discussions. We have appreciated this opportunity and continue to be available as the state moves forward with its effort. The KanCare RFP that was released late last year included several provisions that were supported by hospitals and health care providers. These provisions included the requirement that the Medicaid contractors create an advisory committee to receive regular feedback from providers and other stakeholders, encouraging contractors to work with existing provider networks, implementing a uniform provider credentialing form, preserving the benefit of existing add-on payments, enforcing prompt pay requirements, and ensuring Medicaid reimbursement does not fall below the current fee-for-service rates for contracting providers. While these provisions are among several that are lauded by the health care provider communities, there are still several provisions that will need to be vetted. One provision that has caused some trepidation among hospitals involves lowering the reimbursement rate to 90 percent of the fee-for-service rate for non-contracting hospitals. This provision may provide an unfair advantage to the Medicaid managed care organizations during contract discussions.

Hospitals are significant stakeholders and providers of care for the State's Medicaid enrollees. As such, we recognize the tremendous task in front of all us in reforming and redesigning the program to match the vision "To serve Kansans in need with a transformed, fiscally sustainable Medicaid program that provides high-quality holistic care and promotes personal responsibility." We stand willing, as hospitals always have done, to be partners in helping the State achieve that vision.

Thank you for your time and I would be happy to stand for any questions.