KANSAS MEDICAL SOCIETY
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To: Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and Kancare Oversight

From: Jerry Slaughter
Executive Director

Date: October 7, 2013

Subject: KanCare

The Kansas Medical Society appreciates the opportunity to offer the following comments on aspects of KanCare related to reimbursement, access, and quality of services, from the perspective of the physician community.

First, it should be noted that throughout the planning phase and early implementation of KanCare, the administrative team at KDHE, led by Secretary Moser, has done an exceptional job under a tight timeline and difficult circumstances. They have been very responsive, accessible and fair about their approach. While the provider community continues to experience problems in some aspects of the KanCare rollout, as noted below, Dr. Moser, Kari Bruffett, and their staff have all been extremely helpful, available and willing to listen.

KMS is a statewide association which represents nearly 4600 physicians in all medical specialties. While health care is certainly a team effort that integrates many health professionals in the delivery process, physicians are the foundation of our health care system. For any systemic reform of Medicaid to be successful, the physician community must be meaningfully engaged as partners in the process. We have a long history of encouraging physicians to participate in the Medicaid program, to ensure that the population served by the program has access to a broad provider network, comparable to that which serves the private insurance markets. Historically, nearly nine out of every ten Kansas physicians has participated in Medicaid, and we continue to encourage our members to participate in this important public program that serves nearly 350,000 Kansans.

We know many are still skeptical about the significant expansion of the role of managed care organizations (MCOs) to the broader Medicaid population. However, the managed care model does give the state the ability to predict, and fix, its costs in the program with some certainty. But as importantly, it also gives the state an opportunity to improve care through better care coordination and reduced program fragmentation, improved quality and outcomes, slower growth in costs, and the avoidance of further provider payment cuts. There isn't anything magic about the managed care model. It is just hard work, being accountable for outcomes, 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.
We, like a number of other organizations, have made several specific recommendations to help improve communication and assist with policy development, especially during this first, transitional year of the program. We have encouraged KDHE and the MCOs to standardize administrative functions, including prior authorizations, care transitions, medical policies and procedures, and credentialing and appeals, whenever it was possible. We have also urged the elimination of 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. While some progress is being made on many of these issues, we recognize that it is a challenge for KDHE to get three well established private MCOs, all having different operational policies and technology platforms, to agree to and implement uniform or standardized processes.

Not surprisingly, one of the areas in which we receive the most concerns from the physician community is in the area of claim adjudication and payment. And while all would like Medicaid to pay better, the present concerns are more related to either slow or no payment, or incorrect payment, or just simply lack of communication on claims issues on behalf of the MCOs. We receive complaints from our members about all three of the MCOs in this area. Some practices have substantial accounts receivable that can go out 60-90 days and run into the thousands of dollars. We also hear from practices that the MCOs do not consistently and clearly communicate with them about claim-adjudication issues, or they are non-responsive to inquiries. Another payment related issue has to do with prior authorizations, which if not done on a timely basis can delay care, increase administrative costs for providers, and delay payment for medically necessary services. However, in recent meetings with KDHE on these issues, KDHE has made it clear that they are intensifying their oversight efforts in this area and demanding more responsiveness from the MCOs. We are very hopeful that with KDHE's leadership and involvement, the payment-related issues and bugs will be worked out satisfactorily prior to year's end.

The Kansas physician community recognizes that redesigning the Medicaid program wouldn't be easy or without some operational or policy problems along the way. While we would of course have preferred that there wouldn't be implementation problems with KanCare's startup, it is not surprising, given the fact that the state had to move nearly 350,000 patients into an entirely different delivery system involving three new MCOs in a very short period of time. I would reiterate that KDHE is very much aware of, and working to address, the problems that the provider community is experiencing with the MCOs. KDHE is sincere in its commitment to make this program responsive to and effective for both providers and patients alike. KMS remains committed to working with KDHE and the MCOs 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.