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Before: Senate Ways and Means Committee

By: Carol Steckel, Senior Director, Alliance Development, WellCare Health Plans

Regarding: SB 300

Chairwoman and members of the committee, thank you for the opportunity to provide feedback on SB 300. We strongly encourage the state of Kansas to continue its groundbreaking, innovative path toward comprehensive, coordinated care for Medicaid beneficiaries by moving forward with the current RFP and procurement process. A reprocurement of Kansas' Medicaid contracts provides an opportunity to level-set the state's Medicaid program, its desired outcomes for beneficiaries and its benefit structure, while building a system that ensures the right service at the right time for the right person.

Kansas, like many states, wishes to build on and strengthen its KanCare program, including better care coordination and savings in the Medicaid budget. An integrated, capitated managed care model provides several advantages for Medicaid beneficiaries across the nation. Examples of successes in other states include:

- In New Jersey, since implementing the long-term care program in 2014 for the ABD population, the scope and availability of services for the population group has increased. Specifically, of the 48,000 ABD beneficiaries enrolled in the state's long-term care program, 30,000 are receiving community-based care.
- In New York, 90 percent of the ABD population served by the state's long-term care program reports that its functional ability has stabilized or improved over a six- to 12-month period.
- In Texas, from 2010 to 2015, capitated managed care payments for the ABD population resulted in savings of $3.8 billion, or 7.9 percent of estimated fee-for-service expenditures. When Federal Medical Assistance Percentage (FMAP) and premium tax revenue were taken into account, the estimated savings to the state from managed care during this period was $2 billion, or 10.2 percent of the state's share of projected fee-for-service expenses.
- In Pennsylvania, the managed care program strongly relies on capitation payments for its ABD population and was found to generate more than $3 billion in state savings relative to fee-for-service between 2000 and 2010. Moreover, the state expects similar savings from the program from 2016 to 2020 in the amount of $3.8 to $4.4 billion compared to fee-for-service.

The current RFP process enables Kansas to continue building its comprehensive, coordinated, person-centered system of care. By applying these principles to the healthcare system, the state will achieve budget predictability and improve the quality of care and outcomes for Medicaid beneficiaries served. This coordinated system also provides the state with the opportunity to clearly set out its expectations and metrics in the managed care contract with ongoing, timely monitoring.

A true partnership between the managed care organization, the state and the members served is the only way to improve the system. Returning to a standard fee-for-service system or a limited managed care program continues the fragmentation and higher costs of our healthcare system. The RFP process and routine competition enables the state to choose health plans that put the member at the center of their activities beginning with care planning and case management. The health plan is only successful when the health status of the member improves or is stabilized.

Health plans are also dependent on the provider network in the state, including case managers. It is important to ensure health plans are not taking the provider community "for granted" and that there is a true partnership between the health plans and the providers. Support systems for providers that enable them to better care for their patients and become financially successful should be the goal of the state and the health plans. Value-based purchasing programs that meet providers where they are, enabling them to evolve and grow ultimately into patient-centered medical homes while participating in the savings achieved when their members' health improves, is a vital part of managed care.

It is important to carefully review the reasons for the budget increases under managed care. While we believe strongly that managed care—full comprehensive coordinated care—is the only way to achieve the triple AIM of improved health care, efficient healthcare and lower costs, it is not going to eliminate costs increases that are due to the increased number of beneficiaries or changes imposed by the Federal Government such as the insurance tax. Managed care is a system that efficiently and effectively uses taxpayer dollars entrusted to the Medicaid program and provides predictability per member per month.

By not providing competition, and by not moving forward on the current RFP process, Kansas is guaranteeing a continuation of the same programs, the same problems and the same issues facing the state. It is only by open and transparent competition that the state will be able to ensure compliance with its goals and requirements. Accountability is vital and must be an ongoing, significant part of the managed care program. A managed care plan being held accountable to its customer, the state, is vital to ensuring innovation, compliance and creativity.

Finally, managed care is an investment—an investment in the healthcare system, an investment in the provider community, and most of all, an investment in improving the healthcare status of a very complex population. It is not something that can be done overnight. It requires constant monitoring, reviewing and revising. But done right, we can achieve the ultimate goal—healthier communities across the state.

Thank you.