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Senate of Maine
Senate District 24

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Testimony of Sen. Roger Katz
LD 1487, "An Act to Implement Managed Care in the Mainecare Program"
Joint Standing Committee on Health and Human Services
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Senator Craven, Representative Farnsworth and distinguished members of the Joint Standing Committee on Health and Human Services: My name is Roger Katz and I serve District 24 in the Maine Senate.

This is my second term in the Maine Legislature. During my first, I was honored to be a member of the Appropriations Committee. A significant portion of our blood, sweat, and tears was focused on our Medicaid program. I found it to be a system almost out of control. The fee-for-service program is spending billions of dollars with little concentration on prevention, inadequate accountability, and huge and frequent cost overruns.

For years now, Medicaid, or Mainecare, has been eating up a larger and larger percentage of our General Fund budget. The phrase "crowding out" applies here: the ever increasing demands of Mainecare have been persistently crowding out our ability to educate our kids, fix our roads, and provide adequate public safety. In the last three years, despite the best efforts of a bright and hard-working Commissioner in her excellent staff, we have continued to struggle with cost overruns, budget instability, and little evidence that we are actually getting good health outcomes.

We can do better. Other states are doing better. We can do better for our Mainecare enrollees, for budget predictability, and for taxpayers. I'm convinced the best path forward is managed-care, or is it as it is called today, "care management". It is not a new untested theory. The concept that is been around awhile now. Many states have implemented managed care. Some have done it well and some have done it poorly. The point is there is a significant pool of experience out there and we can learn from the mistakes of others and build upon best practices that have shown proven results.

I want to make it clear that LD 1487 has nothing to do with how many people we should or should not have on Mainecare rolls. No matter what your view is of our eligibility standards or whether we should or should not participate in Medicaid expansion, Mainecare managed-care will still make sense. The issue is how we take care of those people who are enrolled.

The basic framework of a managed care system is relatively simple. Working with a variety of stakeholders, the Department would create a Request for Proposals and ultimately select three or four

"managed-care plans" which would essentially compete for enrollment of Mainecare patients statewide. If qualified, at least one of those plans would be a non-for-profit Provider Service Network, like a Martins Point, for example. Each applicant would have to be nationally accredited, have policies for the prevention of fraud and abuse, have experience serving similar populations, provide for the availability of primary and specialty care physicians in the network, provide for additional benefits such as dental care, and have an established or commitment to establishing in-state presence. Each plan would have to cover the entire state and all populations, so that they could not cherry pick a particular geographic area or population. Each plan would have to set up a network of providers adequate to cover the population.

One of the keys to making this work is that each provider would be "at risk". That is, they would be paid a capitated rate for each enrollee who signs up with them and the plan would then manage the care of and provide care management for each and every enrollee within that global figure. "At risk" is key to making the system work. The provider must have a significant financial incentive to help manage the health of its enrollees so that the total cost of healthcare will go down without impacting health outcomes in a negative way. Any not-for-profit network would have an option to take up to two years to ram up into fully "at risk" status.

Without getting into the weeds too much, there are essentially two ways in which a capitated plans can save money. On way is bad, the other good. The bad way is to simply make it difficult for enrollees to get care by denying access, making it difficult for providers to get paid, or by reducing provider reimbursement rates. The good way to save money is by doing a more effective job of preventative care and actually managing in the care of the patient through our complicated healthcare system. Let me give you one example: a pregnant woman with a healthy full-term and full weight birth can end up costing about $10,000 if the mother gets appropriate prenatal care and has a safe and well-managed delivery. However, a poorly managed pregnancy ending up in an early, low weight birth may cost ten times more with a far less healthy child at the end. This is but one example of how proper care management can result in better health outcomes for lower cost.

So how do we make sure? How do we make sure that the money gets saved in the "good way" rather than "bad way"? The devil is in the details, and the details are in the Request for Proposals and the actual contract itself. I am told that a good managed-care contract can literally run a couple hundred pages. LD 1487 makes it clear that the RFP and the contract must include details and promises about care management, physician compensation, hospital compensation, access to services including the regional distribution of providers, a fully transparent menu of physician, hospital, and pharmaceutical services available to enrollees, provision for consumer appeals and significant requirements for the collection and reporting of health outcome data. Initial contracts would be for five years, with potential options to renew. Each Mainecare enrollee would have the choice to sign up for any of the approved plans and to change plans on an annual basis. In other states, people change plans on the basis of who is providing the best services, who has the best provider network, and which system is easiest to navigate. The draft also requires each plan to provide a smoking cessation program, a weight-loss program, and alcohol and substance-abuse recovery programs.

You will hear projections that, conservatively speaking, we could be saving $30 million each biennium, money which could go to education funding, tax relief... You name it.

Again, the devil is in the details. The bill calls for a robust stakeholders group, working with the Department, to come up with a Request for Proposals that will lead to detailed contracts to do what we all want to do: achieve better health outcomes and save money.

As you know, we were starting down this path past three years ago when the new administration took over. I know that our terrific DHHS Commissioner has a different approach: a system of ACO's and patient centered homes which have similar goals of improving health come outcomes and saving money. However, I respectfully suggested a best-practices managed care model--- as successfully implemented in other states-- holds out more realistic hope of success here. First of all, the ACO model is largely untried in the Medicaid field, at least as I understand it. On the other hand, care management has been around for some time and a portfolio of best practices has built up. Secondly, as I understand the Commissioner's approach, the ACO system is not an "at risk" system, and although it may have intended to be one eventually, there is no promise of any real savings in the near-term. Frankly, we need savings, and we need them now. Just ask someone in public-school education or higher education. Or ask someone in charge of repairing our decaying roads and bridges. Again, I have huge respect for Commissioner Mayhew, but I just cannot see the expertise at DHHS to go from a regulatory agency and morph into one which is managing a large decentralized system of healthcare delivery. I just do not have the confidence they can pull it off. I have also heard that we should "stay the course" now that we received the SIM grant. However, I have done at least some checking, and the same grant funds could be used just as easily to help us move to a care management system and to do it better. Of the six states given SIM grants this year, three of them are managed-care states. That money can surely help us to set up the stakeholder group, make an RFP and even better RFP, make a contract an even stronger contract and to better track health outcomes going forward.

Others who testify after me will much more knowledge of this complicated and critical area. However, I urge you, both today in work session, to take a hard look at this. Think about it: we have the prospect before us to enjoy better health outcomes and savings in the tens of millions of dollars. This is not a Republican idea or a Democratic idea. This is a best practices, good government idea. Thank you for your attention.