For Senate Finance Committee
Hearing: Wednesday March 25th
HB1112 - Health Insurance Coverage Protection Commission - Study on Individual and Group Health Insurance Market Stability
Position: Favorable

Dear Madam Chair and Members of the Committee,

My name is Alankrita Olson. I am a preventive medicine physician residing in Maryland and a member of Physicians for a National Health Program. I am submitting this testimony in support of HB1112.

In light of the federal Medicaid cuts, Maryland has few options outside of raising taxes, reducing services, or cutting coverage, if additional revenue or savings cannot be identified. This bill is an opportunity to explore a solution for savings: removing Medicaid managed care organizations (MCOs). MCOs are supposed to assume the financial risk for Medicaid costs, reduce spending, and improve care coordination. The reality is far different. The state still covers costs for the sickest beneficiaries that MCOs leave out, while MCOs control their share of the risk by wasting money on administrative hurdles for patients and physicians alike.

From prior authorizations to appealing denials, physicians spend more time fighting the system than we do with our patients. The narrow networks created by MCOs also make it difficult to connect patients to specialists. Recently, a colleague shared the distress she was experiencing from getting a pediatric patient on Medicaid to a pediatric urologist as there was only one in their network which meant a 6 month wait. The distress of dealing with MCOs compounds day in and day out, leading many physicians and other healthcare workers to leave the field.

When Connecticut removed MCOs from Medicaid in 2012 they saw increased physician participation in the Medicaid Program, with a recent 97% physician satisfaction rating. More participating physician plus the eradication of narrow networks meant improved access to care for beneficiaries which led to better health outcomes, with a decline in ER visits and hospitalizations, and an increase in early cancer detection and cancer survival rates. More importantly, Connecticut has saved $4 billion in Medicaid spending since then. If Maryland were to do the same, we could see a potential savings of $521 million a year.

Connecticut utilizes administrative service organizations (ASO) to administer their Medicaid program, and Maryland does the same to administer behavioral services covered within the Public Behavioral Health System, which includes Medicaid beneficiaries. For Maryland, the use of an ASO for behavioral services was motivated by the desire to reduce practitioner administrative burden and to streamline payment, credentialing, and utilization review. This bill allows us to examine how Maryland can best administer a Medicaid FFS program that will reduce practitioner administrative burden and increase

access for patients. An ASO also provides an opportunity to standardize policy on authorization and reimbursement, and demonstrate transparency in financial and clinical decision-making, which is not possible with multiple MCOs.

Connecticut also implemented care coordination programs to improve access and health outcomes. Through the Total Cost of Care model, and now with the Achieving Healthcare Efficiency Through Accountable Design model, Maryland has been a champion of enhanced primary care delivery and improve care coordination for our Medicare population. The Hilltop Institute at the University of Maryland, Baltimore County found that relative to a matched comparison group of Medicare FFS beneficiaries in Maryland, the introduction of MDPCP was associated with significant reductions in Medicare expenditure and inpatient utilization as well as moderate reductions in ED utilization. Removing Medicaid MCOs provides an opportunity to improve care coordination for our Medicaid population as well.

To generate healthcare savings, help physicians provide better care, and improve access for patients, I urge the Health Committee to issue a favorable report on HB1112.