

2018

Orman for Kansas
Problem Solving Platform
Plan 3 of 8

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Revolutionizing Healthcare: Outcomes, Access, and Innovation

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Revolutionizing Healthcare

Access to affordable healthcare is one of the most critical issues facing Kansans. Since 1991, Kansas has gone from being the eighth healthiest state in the nation to the 25th in 2017. This decline has occurred through Democrat and Republican administrations. In short, we have been failing Kansans in the area of health policy for over two decades.

Because it permeates through every aspect of our life and economy, investments in healthcare can lead to a more stable and sustainable future with measurable impact across our state. Over the past eight years, Kansas has taken an ideologically driven approach to healthcare – favoring a national, politically-driven agenda to one driven by common sense. Politicizing healthcare has done a grave disservice to the people of Kansas.

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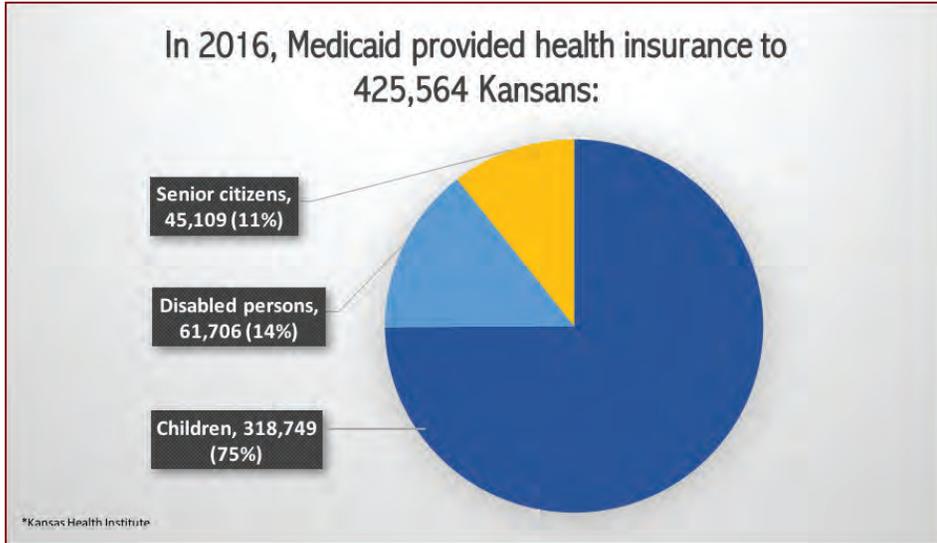


With a more rational policy, we will see significant improvement both in terms of healthcare access and cost. This is not only an issue of public well-being, but also a critical enabler to having a highly productive workforce and rising wages.

Over the past 19 years, median household income in Kansas has barely budged in inflation adjusted terms. As an employer, I know all too well the role sky-rocketing healthcare costs have played in putting a lid on wages. Every year, before we can decide what kind of raises we can give to employees, we first have to answer the question, “How much more are we going to have to pay for our employees’ health insurance?”

In fact, Warren Buffet, the famed investor has recently referred to healthcare costs as, “the tapeworm that’s eating the American economy.” Rising healthcare costs make it harder for companies to grow and to hire more employees. It makes it harder to raise wages. Ultimately, as more and more of healthcare costs get passed onto employees themselves, it makes it harder for Kansans to keep their head above water.

We can revolutionize healthcare in Kansas!



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My Plan

One of the reasons healthcare is so expensive is because the incentives are aligned all wrong. I like to say that healthcare is the only industry that I know of where you get paid to fix your own mistakes. While the Affordable Care Act started to address these misaligned incentives, it still primarily favored increasing coverage over addressing costs and incentives. If we’re going to get better outcomes for lower cost in healthcare, we need to change our incentives. We need to pay for outcomes, not for performing procedures.

While I’m a strong advocate for the free market, just assuming a free market approach will lead to better results for Kansans is lazy and wrong. This is largely the approach we have taken over decades and healthcare costs have skyrocketed, while health outcomes haven’t meaningfully improved. Doing nothing and counting on the free market when incentives aren’t aligned will just lead to more unaffordable care for all Kansans.

The area of healthcare most directly controlled by the state is the Medicaid program. In 2016, Medicaid provided health insurance to 425,564 Kansans, including 318,749 children, 61,706 disabled Kansans, and 45,109 senior citizens. The state of Kansas spends \$3.4 billion annually on Medicaid, \$2.1 billion of which is provided by the Federal government. My healthcare plan is primarily focused on Medicaid, but also touches on making structural changes that I believe will make it easier for the private sector to access lower cost healthcare options.

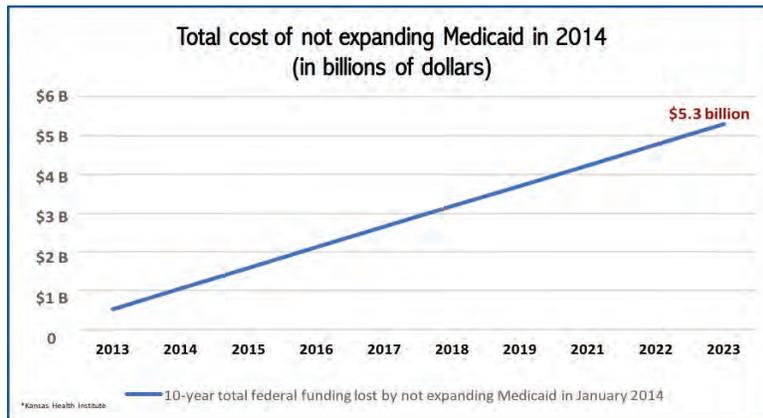
Ray Orman

Addressing Care Gaps in Kansas

There are roughly 240,000 Kansans who aren't covered by health insurance. Various reasons can be attributed for this coverage gap. Regardless of the reason, coverage gaps lead to higher system wide costs as patients get care in the wrong place (the ER) for the wrong reason (chronic conditions) at the wrong time (too late). If we address these care gaps, we can improve the health of Kansans, improve our economy, and help people live fruitful, productive lives in Kansas.

To do this, I am proposing the following:

We need to expand Medicaid in a prudent way, ensuring that the state of Kansas doesn't pay for more care. Currently, the federal government will pay for 90% of the cost of expanding Medicaid. By modifying the program in ways described below, and incorporating state taxes paid by our healthcare industry on their increased revenues, I believe we can expand Medicaid on a cost-neutral basis to the state. Expanding Medicaid is not about offering a "giveaway" as some would paint it. It's about taking a broader view of the situation and making smart and practical decisions about what is economically best for Kansas.



Expanding Medicaid is also a matter of fairness. In Kansas, to qualify for Medicaid through the KanCare program, an individual needs to earn less than 38% of the federal poverty level (FPL). For a single mother with two kids that means if she earns more than \$7,900 per year, she doesn't receive Medicaid. To get subsidies through the Affordable Care Act at the Federal level, she needs to earn 138% of the FPL, or almost \$29,000 annually. So, a single mom with two kids at home who earns between \$7,900 and \$29,000 per year is on her own when it relates to paying for her healthcare. If she gets sick, we send her a perverse message – quit your job.

That's not the message we want to send. We want to give people incentives to improve their lives, not put obstacles in front of them. It's also unfair that we would provide up to 80% of the cost of purchasing health insurance for someone making more than \$29,000 per year, but provide no help to someone making half as much money.

From a workforce development standpoint, we also put the state of Kansas at a significant disadvantage to the 33 other states that have already expanded Medicaid (in part, using dollars that Kansas taxpayers send to Washington DC). Someone making \$13 per hour in a family of three in Colorado gets healthcare coverage as part of their decision to work in Colorado. That same person in Kansas gets no healthcare coverage unless an employer provides it. Given the shortage of workers in Kansas, this puts us at a significant disadvantage.

Finally, there are a number of Kansans with chronic health conditions who would like to work more. Given the current thresholds for receiving healthcare, however, they are limited in how much they can work. As one particular Kansan put it to me, "I would like to work more, but if I do, I can't afford my medication." As we look to address workforce shortages, these sorts of disincentives to work are clearly hurting us.

In order to expand Medicaid in a way that doesn't cost the state of Kansas money, we need to petition CMS for a waiver to allow us to modify our Medicaid program in the following ways:

First, we should establish a system of Direct Primary Care for Medicaid patients and adjust the elements of care the KanCare providers are responsible for providing.

Direct Primary Care can be delivered either through Community Health Centers, physician practices, or dedicated PAs and Nurse Practitioners located in locations with lower populations of Medicaid patients. Under this system, patients would get their wellness, preventative care, acute care, and some chronic care management directly through these organizations. Generally, delivering care through these alternative channels is significantly lower cost.



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By moving to direct primary care, we'll also be able to take more of a population health approach and focus on keeping people healthy instead of just treating them after they are sick. This has been proven to be a far less expensive approach. It significantly delays or otherwise avoids the onset of certain diseases that are driven, in part, by lifestyle decisions, such as diabetes, liver disease, many cancers, and cardiac related conditions.



Direct primary care providers who want to participate in the system would bid on providing a suite of services to specific Medicaid populations. We would measure their care delivery and outcomes and adjust their compensation based on their performance. Ultimately, this would give them an incentive to keep their patients healthy, ensure patient compliance with care instructions, and intervene earlier to address conditions before they progress.

KanCare providers would still provide healthcare for catastrophic care, emergent care, and the management of certain chronic conditions.

Second, we should have patients participate in a portion of their healthcare costs as they earn more money. While we want healthcare to be affordable, we also want to give people an incentive to use our healthcare resources wisely and to make smart decisions about their own choices. As people's incomes scale from 100% of the FPL to 138% of the FPL, they should pay a portion of the cost of their care.

We already have a system in place to manage cost-sharing by patients, which is used by Federally Qualified Health Centers. Patients who earn above certain thresholds are expected to contribute a portion of the dollars associated with the cost of their care. We could easily adapt the system and apply it to Medicaid patients who earn more than the Federal Poverty Level.

Finally, we should allow Kansans who are uninsured to access the lowest price for care. Today, insurance companies, both public and private, negotiate rates with healthcare providers. They use their ability to buy services in bulk to reduce the rate that they pay for their patients' care. While expanding Medicaid would significantly reduce our uninsured population, we will still have a population of people who are uninsured for various reasons. Today, those people are charged the highest rates for care. This is unacceptable. Our most vulnerable populations shouldn't be paying the highest price for care. We should mandate that they receive the lowest negotiated rate for care to insure that a healthcare crisis doesn't put them into bankruptcy or otherwise encourage them to quit their job to qualify for Medicaid.

Innovation and Accountability in Healthcare

We need to recognize nutrition as a critical element to wellness and eliminate food deserts where individuals can't access fresh fruits, vegetables, and meats. It is unacceptable that fresh food deserts exist in a state like ours with so much agricultural production. There are a number of communities in Kansas, particularly in urban and some rural areas, where our fellow citizens don't have easy access to fresh food. They find themselves eating heavily processed foods, high in saturated fats and sugars. I'd like to work with local communities to come up with a shared approach to addressing these fresh food deserts.

Given the connection between nutrition and health, a limited investment would likely lead to significant improvements in health outcomes and lower costs. It would also significantly improve the quality of life for many Kansans and help build lifelong habits in our children that would lead to far better lifelong health.

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In 2017, the State hired a clearing house to streamline the application process in a centralized manner. The cost to the Kansas taxpayer has been over \$25 million annually.

Telemedicine and other remote care models. Technology has changed dramatically over the last 10 years. Our ability to provide care remotely through the use of telemedicine has expanded. We should fully embrace telemedicine as a way to provide care in areas that are underserved. We should also allow the Direct Primary Care organizations to use telemedicine in instances where transportation, work requirements, or other obstacles prevent Medicaid patients from accessing care. This may be the difference between something like bronchitis turning into pneumonia and costing significantly more resources to treat. I also suspect this would de-clutter waiting rooms that oftentimes feel like a place where infections are transmitted from one patient to another.

Eliminate delays in healthcare delivery due to state bureaucracy. We need to evaluate all the areas where our state interacts with healthcare delivery and determine areas that need to be streamlined. As an example, there is a two-year delay in certifying renal dialysis facilities in the state of Kansas. In many instances, Kansans are traveling several hours multiple times per week to get dialysis treatment, while a completed facility that has yet to open because of these bureaucratic delays is just fifteen minutes from home.

The other area where we have fallen short is the application process for KanCare. In 2017, the State hired a clearing house to streamline the application process in a centralized manner. The cost to the Kansas taxpayer has been \$25-million annually. The contractor failed badly and the state of Kansas failed in its management and oversight responsibilities. This may be the directly result of having a governor with no real world business experience. Applicants who were denied coverage due to technical reasons with their application are forced to start the process over – taking significantly more time and wasting resources. The net result of this ineffective contract is that we are 15,000 applications behind – leading to over a year delay in qualifying for care. Instead of fixing the problem, the state has conveniently played the blame game.



We need to transition away to this outsourced approach to application management and reintegrate the application process into a network of area agencies for aging and other social service agencies. We then need to closely monitor the process and provide monthly accountability for eliminating backlogs and improving the quality of the process.

We need to examine our systems to ensure that we are using information in the most efficient ways. As an example, KanCare providers spend a significant amount of money treating newborns in the Neonatal Intensive Care Unit (NICU). One of the reasons for this is that KanCare providers are not notified of a pregnancy in a timely manner. Early intervention is critical to providing effective prenatal care, particularly when substance use disorders exist. Specifically, there's no change in the eligibility code for existing KanCare members when they become pregnant. This delays their ability to identify the member early in her pregnancy.

Pregnant women also may be reluctant to discuss substance abuse with their Provider or case manager in fear of DCF involvement. We need a better response to this problem – one that encourages pregnant women to seek prenatal care without the threat of tearing her family apart. A combination of better reporting and a more compassionate approach to Kansans seeking care for their substance use disorders would lead to better health outcomes and significantly lower costs.

Finally, we should give KDHE the flexibility to adapt the Medicaid program in Kansas when clear improvement opportunities exist. Requiring legislative approval for innovations in care delivery can lead to wasted dollars and lower quality care. We need to be able to embrace innovations when the evidence suggests they lead to better outcomes.

Reduce Prescription Drug Prices

We should proactively and aggressively pursue reduction in prescription drug prices through the Medicaid program. Currently, Medicaid provides prescription drug coverage. Under the rules established by the Federal Government, if we want to be able to offer this coverage to Kansans, we need to be willing to provide every drug that the FDA has approved for sale. The price we pay is a 24% discount off the retail price that is set by the industry. We only get a small portion of that discount – the federal government gets the majority of it. As a result, we essentially are a price taker. If the industry wants to earn \$10 a pill, they set their retail price at \$13. If they want to earn more, they simply raise their prices and there's nothing we can do about it.

Kansas has a waiver from CMS that allows to negotiate prescription drug prices. We need to make certain that we are using the best available information to get the most value for the dollars we spend. There are many databases available that identify what a drug should cost based on how well it works. We should use this information to ensure that the price we pay reflects the value of the drug being prescribed. We shouldn't be forced to significantly overpay for a drug that is simply well marketed, but only improves outcomes by a proportionate amount. I believe this approach will lead to millions of dollars in savings to the state of Kansas.



Proactively Address the Opioid Crisis

While the opioid crisis hasn't affected Kansas to the same extent that it has other states, the rate of opioid use disorder has been increasing in Kansas. To get ahead of the crisis, I would propose the following approaches:

We should embrace best practices from other states such as Virginia that use non-addictive medications to wean addicts from opioids. There are three drugs approved by the FDA to help wean patients from their addiction to opioids. Often these medicines are delivered through the Medicaid program. While I realize there's a push to drug test Medicaid recipients, such an approach would set us back in trying to treat opioid use disorders.

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We should also encourage emergency rooms to offer these medicines to individuals coming in with withdrawal symptoms when they can safely do so. In a 2015 study at New Haven Hospital in Connecticut, patients that were given one of the three drugs, Buprenorphine, were twice as likely to be in a treatment program a month after their emergency room visit. Not giving patients these options when they are seeking help for severe withdrawal means losing a critical intervention opportunity. We need to make sure the other elements of care delivery are available after starting these treatments to ensure they lead to lasting changes.

Give providers the freedom to prescribe cannabis as an alternative to opioids for pain management. In states that have allowed physicians to prescribe medical cannabis as part of their pain-management protocols, they have seen statistically lower rates of opioid use disorder. Medical cannabis has also proven effective in treating the symptoms from other conditions, such as cancer, epilepsy, and arthritis. Giving doctors, who can prescribe Schedule II drugs, the freedom to prescribe medical marijuana would help curtail the growth in opioid use disorder.

I am aware that enacting effective healthcare reform in Kansas will be a complex and challenging task. Capturing these opportunities will require hard work and an innovative approach. What we've seen from the major parties range from "let the free market deal with it" to "let's throw more money at how we are doing things today." We will never get at the opportunities that exist. There is a way to get to better outcomes, greater access and lower cost if we take a more responsible approach to healthcare.

Greg Orman