INDEPENDENCE
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INTERHAB

January 17, 2012

TO: Senator Vicki Schmidt, Chair,

Members, Senate Public Health and Welfare Committee

FR: Tom Laing, Executive Director, InterHab

RE: "KanCare" Proposed Managed Care and the Kansas I/DD Long-Term Care System

Thank you, Madam Chair and members of the Committee, for the opportunity to speak to you today regarding the Administration's proposed global changes to State Medicaid-based programs and services, and particularly, the community-based supports that thousands of Kansans with intellectual and developmental disabilities depend upon each and every day. KanCare is predicated on the concept that expenditure of Medicaid funding can be improved, and that more efficient administration and better outcomes can be expected from such an approach. We do not oppose this approach for the better management of medical and mental health services. However, we oppose the incorporation of long-term service funding for persons with intellectual/developmental disabilities into the KanCare contracts. We urge the Committee to take steps needed to assure that the HCBS DD Waiver (and ancillary support funding for targeted case management, employment services, etc.) for persons with I/DD not be included in the KanCare program.

KanCare is predicated on incomplete data:

Medical costs in the Medicaid program are escalating, but two facts need to be noted regarding services for persons with I/DD:

- Overall, non-medical spending on Kansans with I/DD, since 1993 (when Kansas began to rely on the waiver for DD program financing), has decreased from a $49,418 per-person, per-year average to a $41,936 per-person, per-year.

- Medical spending for persons served in the I/DD network has also declined in recent years. According to numbers received from the Kansas Legislative Research Department, during the years from 2008-2011 pharmaceutical spending has declined from $21.3 million to $18.5 million per year, hospital spending (inpatient and outpatient) from $9.3 million to $7.2 million, and physicians and clinics expenditures have declined from $3.9 million to $3.0 million.

These numbers illustrate the efficiencies of our network, and the outcomes arising from the careful attention paid by our programs to the medical needs of persons we serve. These numbers also illustrate that our programs are not the contributors to the problems that KanCare proposes to address.

<u>The case for removing I/DD long-term care services from KanCare:</u>

A. KanCare is a medical program, I/DD long-term care is <u>not</u>:

It is important to understand that the use of Medicaid money does not mean our programs are medical, it only means Congress expanded the uses of Medicaid to include the day and residential services for persons with DD which had previously been offered in State or private intermediate care facilities. Since the beginning of the Medicaid waiver program, medical benefits have not been a part of the waiver, they have been a part of the State Medicaid plan.

The waiver does not provide medical care.

We understand the logic of placing medical spending into KanCare. The physical health and mental health networks have indicated they support the KanCare approach, and we respect the positions they have taken. However, long-term care services are not medical. Our services are solely related to the identified daily living needs of persons we serve.

MCOs with whom we have spoken have indicated to us (1) they do not have broad experience with DD long-term care service provision, (2) they do not anticipate any savings that can be found, and (3) they do not know why this model is being rushed into service.

B. KanCare will complicate the current model of long-term care, mandating new layers of administration and contracting:

The current model operates with:

- A single state CDDO contract, which spells out the management roles of the CDDOs, and must be signed by every CDDO.

- A single Medicaid provider agreement, which authorizes qualified providers of services to bill for services which are a part of a "plan of care" that must be approved by the State and CDDO.

The KanCare model:

- Will replace the single State authority with three contracted authorities, each of which will fulfill many of the operational roles currently held by the State, and each of which will have its own individualized contract with the State.

- Will require four separate CDDO contracts for each CDDO, one with the State, and one each with the three MCOs, each of which will have its own unique contract.

- Will require each community service provider to maintain its affiliation agreement with any CDDO where it intends to provide services, plus three individual contracts with the three MCOs.

C. Administrative complexities will translate into higher administrative costs:

- The new layer of contracting will require community organizations to acquire broader expertise in the negotiation of such contracts, considering that the contracting process with MCOs will include a greater set of issues from the private for-profit world of insurers.

- Considering that each person will either select (or be auto-assigned to) one of three MCOs, the complexities include a very real scenario in which a group-living residence housing three persons

could literally require three contracts to serve the three persons, with three separate reporting requirements, billing requirements, auditing requirements, and so on…

- It seems certain that current service dollars will be squeezed in order to accomplish the expanded administrative activities certain to be found in the KanCare model. Additionally, fraud or simply administrative errors are far more likely to occur with such a three-headed approach to program administration.

- The State will need to add sufficient employees to oversee program integrity especially in the face of such massive changes; but if they do, then the question has to be asked as to why the systems have been changed so dramatically as to necessitate such additional investments in oversight.

Our interaction with the Administration and our conclusions:

We have worked regularly with the Administration for almost a year. Our basic position has not changed. We do not believe that the long-term services we provide belong in KanCare.

This Administration deserves high marks for their collaboration with us, despite our opposition to their central idea.

They have responded with a number of clarifying statements about how MCO-management of the DD system should be shaped, and the most recent official comment is this:

> *Question: Can you explain further the role of the CDDOs in KanCare, and specifically whether the provisions related to "conflict-free case management" relate to them?*
>
> *Answer: We intend that the role of CDDOs in Kansas, reflected in current statutes, regulations and other governing guidelines, remain as it is today. We want the people who receive services through the CDDO system (directly and by affiliating community service providers) to continue to access their chosen providers, including case management providers. We intend that Kansans will continue to benefit from the strength of that (and other) existing service system, and also to gain from the benefits and resources of the comprehensive KanCare service system – including by increased integration of physical health care services and access to health homes that have specific knowledge about supporting people with multiple health care service needs. More specifically, we will require the KanCare contractors as they develop their provider networks and care coordination/health home infrastructures, to honor the specific powers and duties of CDDOs as reflected in Kansas statutes and regulations, as identified in the RFP …*

With the intentions noted above, the question remains from our original conversations with the Administration:

<u>If I/DD services are intended to operate with little or no difference than the current model, then why invest more than $300 million of long-term support and service funding into MCOs when no changes are being made to the current ways in which long-term services are provided?</u>

Clearly, the answer to that question is **<u>financial</u>**.

We believe that KanCare has been constructed in such a way that I/DD long-term care funding is included in order to "make the numbers work". In essence, the appropriations for long-term care services for persons with I/DD will be unfairly utilized to enrich the KanCare contracts, in a way which only benefits the contracting entities.

Financial resources for persons with I/DD should not be used to "sweeten" the KanCare program. Contractor profits and shareholder earnings should not be extracted from a service network not even targeted for change, with dollars that weren't needed in the program in the first place.

If it is the decision of the Administration and the Legislature to go forward with KanCare as is, we recommend consideration of some additional tightening of the program design:

- All interest earned on KanCare funds should be recouped by the State, and re-invested in program waiting lists and rate adjustments.

- All legislative oversight committees should request statutorily-established subpoena powers for themselves.

- Auto-assignment should not occur for persons whose primary benefits are their DD services.

- Proponents from the Administration and from the Attorney General's Office of Medicaid Fraud and Abuse should provide detailed staffing schemes and responsibility roles for oversight.

Let me close with these questions for you:

1. KanCare will be the largest financial transaction in our state's history. Is there sufficient time for the Legislature to exercise sufficient due diligence to assure that this plan will be adequately devised, implemented and safeguarded?

2. The State's primary safety net investment for persons in need (low-income children, the elderly, and those with disabilities) will now be entrusted into a plan never before attempted in the country? Should additional time be required of the Administration to address the remaining unanswered questions and issues?

3. Is it a proper delegation of legislative and executive oversight that the developmental disability community network and its families and persons served be placed at a distant arm's length from both the Administration and the Legislature, separated by an administrative wall of three separately empowered national for-profit insurance companies?

4. Finally, if this goes forward, is the Legislature prepared to consider how it will respond, in the months after adjournment, in the event that the eventual contracts issued for KanCare are different than the assurances that have been offered received in this process?