**House Committee on Health and Human Services**
**Testimony in Support of the KanCare Accountability Act, HB 2573**
**March 14th, 2012**

Thank you for the opportunity to present testimony on the proposal to contract out all of Medicaid to managed care companies. My name is Nick Wood, I am an advocate at the Disability Rights Center of Kansas (DRC). The DRC is a public interest legal advocacy agency, part of a national network of federally mandated and funded organizations legally empowered to advocate for Kansans with disabilities. As such, DRC is the officially designated protection and advocacy organization for Kansans with disabilities. DRC is a private, 501(c)(3) nonprofit agency, organizationally independent of state government and service providers, whose sole interest is the protection of the legal rights of Kansans with disabilities.

This bill would require an Audit of KanCare one year after its implementation. We support the bill and ask for additional provisions and protections.

In addition to the Audit provisions in this bill, we urge the Legislature to also amend the bill to do the following:

**1. Delay KanCare, and**

**2. Develop an Oversight Commission in order to reassert the Legislature's authority to fund, create, and oversee programs, like KanCare.** The power to appropriate, an inherent power with all programs like KanCare, solely rests with the Legislature in our State's Constitution. Thus far, the Legislature has been excluded in every provision of the new KanCare program. The Legislature cannot

not and must not abrogate its authority. The Legislature must appropriately engage to ensure oversight of the largest managed care HMO shift with all Medicaid in our nation's history. The way to do that is to establish an oversight Commission.

**Ensure Legislative Oversight**

One method for ensuring Legislature's proper role in the appropriation of funding is to with regard to KanCare is to establish an Oversight Commission. A Commission on Medicaid managed care oversight which would better position the legislature to advise the State Departments on the planning and implementation of a system of Medicaid care management and monitor such planning and implementation on matters including, but not limited to, eligibility standards, benefits, access, and quality assurance.

**Pass laws to limit impact of poorly written or poorly implemented managed care plans**

Several committees in the House and Senate have heard suggestions to carve out certain service systems, or to delay and *'phase-in'* implementation. We further strongly suggest the Kansas Legislature also use its lawmaking authority to **establish limits on profits, ensure there are requirements for community reinvestment, and make performance measures meaningful**. In essence, the Legislature could CAP the Administrative costs the for-profit companies can charge under KANCARE.

For this kind of reform, contract terms are key. Contract terms between the state and the Health Maintenance Organization (HMO) and of course the sub-contracts the HMO has with its subsidiary Managed Care Organizations (MCOs) and, then, of course, the multiple other contracts and provider agreements that those MCOs will enter in to will carry the details that mean the difference between **accountable success** and **harm**.

- The contract defines what the money is spent on—profit, incentives, administration, and service delivery.
- The contract sets the performance indicators.
- The contract defines accountability mechanisms.

***The bottom line for successful managed care?*** Performance improvement partnerships across payers, providers, and other agencies (including state agencies), and stakeholders. It is also essential that savings be reinvested in the HCBS and Behavioral Health system to address unmet needs, rather than go excessively to the MCOs.

**What are the risks?**

We want to leave the committee with just a few examples of what we are afraid will happen if the Legislature does not assure oversight and accountability for KanCare.

1. **Large profits that are derived from Administrative Claiming, not actual service delivery and improved health outcomes.**

   Kansas has a history with exorbitant administrative claiming costs to managed care companies. These costs are public dollars that go straight in the pockets of out-of-state, for-profit companies.

   The HMOs will tell you that they need that money to 'operate' and the state agencies may tell you that they need to allow high administrative claiming caps in order to attract competitive bidders, but we know that this creates a terrible incentive for the companies. When admin claiming is high, there is lower incentive to derive profits from where they need to be made, from incentives for improved health outcomes.

   There are good examples across the country where states who made well informed decisions with managed care did not have to pay out large administrative rates to get good quality.

2. **Denied care and treatment services via a bureaucratic 'prior authorization' process.**

   There are also a plethora of examples across the country that show the effects of managed care that are not able (or are not incentivized to) meet the demands under contract. The result is often a confusing and bureaucratic process to grant "prior authorization" for medical services within two weeks – the national standard for the time a health-care plan should take to grant or

deny coverage to a patient. If KanCare companies cannot meet this standard right out of the gate on January 1st of next year, we will potentially be putting patients who need coverage for medications, tests, or other critical medical services and equipment at risk.

State's who have experienced these problems have been besieged with complaints from doctors, hospitals, and other healthcare providers who say reforms have created a highly bureaucratic system – another challenge for doctors and hospitals to deal with as they care for a growing number of uninsured patients and wrestle with a lower rate of federal reimbursements for medical services.

3. **Disruption in Care**

With such a hurried implementation schedule we feel there are bound to be big problems. We worry that what has happened in other states will happen here. There are further examples of people with complicated medical histories being suddenly forced to find new doctors or new drugs. They have to deal with a whole new set of circumstances which can easily disrupt their care. Until we know the details and make sure there is a proper level of care, it’s not a budget savings, it is literally kicking the can down the road because choosing to not meeting health care needs now, will certainly mean higher costs later. We want to ensure there is no disruption in care that would damage client health and ultimately lead to much higher costs for taxpayers