Testimony to House Health and Human Services
House Bill 2169

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Mister Chairman and members of the Committee, my name is Colin Thomasset. I am the Associate Director for the Association of Community Mental Health Centers of Kansas, Inc. The Association represents the 26 licensed Community Mental Health Centers (CMHCs) in Kansas that provide behavioral health services in all 105 counties, 24-hours a day, seven days a week. In Kansas, CMHCs are the local Mental Health Authorities coordinating the delivery of publicly funded community-based mental health services. As part of licensing regulations, CMHCs are required to provide services to all Kansans needing them, regardless of their ability to pay. This makes the community mental health system the "safety net" for Kansans with mental health needs. CMHCs served over 135,000 Kansans in 2016, which we believe is more than ever before.

We appreciate the opportunity to provide testimony in support of HB 2169 which would establish additional mechanisms for appeals, uniformity, oversight, and transparency of the Kansas Medicaid Program, especially as it relates to the Managed Care Organizations (MCOs) contracting with the Kansas Department of Health and Environment (KDHE) to administer the program. Some of the facets of HB 2169 that are of particular interest to CMHCs are as follows:

- Uniformity of access to patient encounter data;
- Uniform processes for provider credentialing and claims processing;
- Prior authorization procedures;
- Caps on administrative spending of MCOs; and
- Streamlined appeals processes.

Much has been asked of providers to comply with KanCare, and we believe that the same expectations should exist of MCOs. For example, we saw one MCO request extraordinary amounts of documentation for the purpose of review before they would agree to pay. This occurred shortly after the four percent Medicaid rate reimbursement reduction was implemented after the Governor's allotments in May 2016. Pre-payment review processes should not occur without clear and convincing evidence of inaccurate billing. This project was eventually abandoned but not before providers had spent significant amounts of administrative staff time to comply with the request.

The administration of KanCare should be as streamlined and uniform as possible. Our message is also to the parent companies of the health plans doing business in Kansas. That message is to allow the state plans to do their jobs and work directly with providers to get the necessary treatment to patients on Medicaid. Our system has some uniqueness to it in that we not only end of up in a position to deal with the state and national plans which do not always effectively communicate but also with state and national behavioral health subsidiaries. This creates and extremely cumbersome and bureaucratic process requiring more time and administrative cost than the Medicaid program that existed prior to managed care.

We would be remiss by not mentioning some of the promise we believe that still exists for KanCare. One example is a proposal that was brought to our system by one of the MCOs that allows CMHCs to partner with them on outcomes relating to health measures. The MCO created scorecards showing

each CMHC's performance for certain measures. Achievement of each measure will result in a bonus payment that reflects overall care for the patient. We appreciated the leadership of this MCO and its CEO in taking the time and investing in a dialogue and partnership with the CMHCs. KDHE has been supportive in this initiative, and we hope that this will be embraced by the other MCOs, and in time, become the rule rather than the exception in our partnerships going forward.

Thank you for the opportunity to appear before the Committee today, and I will stand for questions at the appropriate time.