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To: Health and Human Services Committee

From: Ron Pasmore

Date: March 14, 2012

RE: HB 2457

Thank you for the opportunity to speak in support of HB 2457, which seeks to exempt HCBS Waiver services for persons with Intellectual and Developmental Disabilities (ID/DD) from, managed care. I am Ron Pasmore, President/CEO of KETCH, an organization that provides services to persons with ID/DD in Sedgwick County. I have served as co-chair of InterHab's managed care workgroup with Sharon Spratt, CEO of Cottonwood in Lawrence. At one of our early meetings with the Lt. Governor over a year ago, where we recommended that ID/DD services be excluded from managed care, he recommended that we take a close look at Kentucky as it served as the model where Kansas was headed. KanCare indeed appears to mirror Kentucky's Medicaid managed care program of – including award of contracts to three of the five managed care companies under consideration in Kansas. However, there is one big difference – Kentucky's program excludes non-medical HCBS services for persons with ID/DD.

Since its implementation on November 1, 2011, the Kentucky legislature has fielded complaints from hospitals, doctors, mental health providers, and patients because of delayed payments and complicated prior authorization processes. Medicaid patients in Kentucky continue to experience tremendous hurdles in getting needed care. I urge each of you to view a website of video testimonials – Kentucky Voices for Health Care at www.kyvoices.com and learn about the problems with managed care in Kentucky. Thus far Kentucky's version of KanCare has resulted in reduced access to medical care, compromised the quality of the care provided, and reduced the efficiency of Medicaid over the fee-for-service program that existed prior to managed care. Providers and advocates state that the managed care companies promised all kinds of things that have not happened – and the problems appear to be getting worse.

With KanCare, the administration has promised that access to services will not change, and that everyone currently serviced will be able to keep the same service provider. They have assured prompt payment at current rates with incentives for the managed care companies to exceed a

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payment standard of 30 days. They have assured that the requirements of DD Reform will be maintained, including the role of the CDDO and the assurance that individuals can keep their current case managers. So what's the problem?

I have received many requests to sign letters of intent (LOI) with managed care companies competing for a contract with Kansas. In many cases, these letters included language that made me question whether we could be included in their provider network if we did not sign the LOI within the timeframe they specified. One of the managed care companies under consideration made a statement during a meeting I attended that they would have the right to offer provider payments at 90% of the current rates if we did not agree to their initial offers.

I received a provider application packet from one of the companies under consideration. It pertains to mostly medical services that we do not provide. It excludes case management services. In reviewing the agreement, I understand that as a provider we will be required to engage in credentialing, record-keeping, reporting encounter data, on-site record reviews, utilization management, quality assurance, grievance, coordination of benefits, third party liability, and other unspecified rules, regulations and policies of the company referred to in their provider manual – which was not included for review. All of these activities will be on top of the existing compliance and regulatory requirements we are responsible for from SRS and our CDDO. We will three sets of these activities – since approximately 1/3 of our clients will be enrolled with each managed care company selected. This is going to be a costly administrative undertaking for us. The provider contract also states that the managed care company's procedures and policies regarding the above mentioned processes are proprietary and prohibits us from disclosing any of this information without prior approval. I fully expect that each managed care company will have similar prohibition of disclosure of what they consider to be proprietary information. We will have to worry that our direct care staff doesn't release something pertaining to these companies to the wrong parent in settings such as group homes where each resident is enrolled with a different managed care company. This will be an absolute nightmare for providers.

I keep asking members of the administration how KanCare will improve the quality of services for persons with ID/DD when it clearly is going to result in higher administrative costs deducted from dollars currently used to pay for care. The answer I am given is better coordination of medical care through use of the Medical Health Home model. Our workgroup has studied this model and found that it actually has nothing to do with managed care, but rather is defined in Section 2703 of the Affordable Care Act. Planning grants were available to States to fund planning activities to implement the Health Homes model last year. States may be eligible for a 90% FMAP for care coordination provided in conjunction with a health home. Many States are doing this. Sharon Spratt and I met some colleagues at a national conference just a couple of

weeks ago who have been directly involved in Arkansas's Medical Health Home planning grant – which seeks to place the Health Home for persons with ID/DD within their equivalent of our CDDO's.

I attended a meeting in Wichita week before last where Secretary Sullivan detailed the six requirements of a Health Home. Of these six criteria, my organization provides five of them. We employ a Registered Nurse, several Licensed Practical Nurses, and a Behavior Specialist. We contract with Galicia family practitioners, a psychiatrist, a local pharmacy, and a physical and speech therapist. The individuals we serve receive comprehensive care management. Our nurse provides coordination of health care services as well as the promotion of health via training for our direct care staff that work with our clients. Our nursing staff and contracted providers provide comprehensive transitional care, which includes follow-up from inpatient or outpatient health services. We provide individual support for our clients and their families regarding their health care needs, and we are actively involved in making needed referrals to community and other support services not directly provided by KETCH. It is my understanding that this is what constitutes coordination of care under the Medical Health Home model. There is one more criteria that we currently do not have the capability to provide which is the use of electronic medical records that link service providers. Because states like Arkansas undertook a period of comprehensive planning that included the existing service provider systems, they were able to build upon strengths that already existed. Unfortunately, Kansas's providers were not included as it was determined from the outset that Medicaid in Kansas was broken and would be outsourced to insurance companies.

In summary, I believe that the managed care model espoused in the KanCare RFP is not appropriate for the provision of the non-medical HCBS services for persons with ID/DD. Kentucky provides chilling evidence of problems with access and quality of services provided by managed care organizations. Luckily, ID/DD services were carved out of their model. Regardless of the assurances within the RFP to hold the current ID/DD service system harmless, initial experience with LOI's and provider agreements tells me otherwise. This is going to put multiple layers of new administrative burdens on providers in order to maintain services for persons with ID/DD. The one benefit emphasized by the administration – coordination of health care by treating the whole person – largely already exists within the ID/DD service network; and could have been built upon instead of starting from scratch.