House Committee on Appropriations
Testimony for HB 2789
March 20, 2012

Thank you for the opportunity to speak before you, my name is Nick Wood. I am the Systems Change Coordinator and Lead Investigator 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 people 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 corporation whose sole interest is the protection of the legal rights of Kansans with disabilities.

The Disability Rights Center supports HB 2789. We see this bill a positive first step by the Kansas Legislature to assert its role in the oversight and accountability in the way public funds are used. Only the Legislature has the Constitutional power to appropriate funding for programs, like KanCare. Inherent with the power to appropriate is the power of oversight as well as program establishment, policy and integrity. HB 2789 is an important first step in ensuring accountability.

In addition to establishing the oversight commission in HB 2789, the Legislature should also adopt the other recommendations contained in the attached Big Tent Coalition policy paper which includes: carving out all HCBS Medicaid Waivers from KanCare, ensuring waiting lists are reduced and eliminated with the implementation of KanCare, support for independent legally-based conflict resolution services, phase in KanCare cautiously (including passing the Senate Resolution to delay implementation by 6 months), etc.

BIG TENT COALITION

Why is Kansas

‘Going All In’

by forcing ALL of Medicaid into managed care?

Why Gamble with the Lives of Kansans?

Kansas is proposing that ALL of Medicaid be contracted out to managed care corporations in what might be the most rushed, “all in” switch to managed care in our nation’s history. Legislators should ask tough questions about Medicaid managed care and demand changes to what is currently proposed. Here are some questions and issues from the stakeholder community and the Big Tent Coalition:

Question: Why is Kansas ‘Going All In’ by forcing ALL of Medicaid – including every HCBS Waiver program – into an immediate, statewide, managed care contract with private, for-profit, out-of-state corporations?

We Recommend: “Carve Out” HCBS Waivers from Managed Care.

- Why is Kansas gambling with the lives of our citizens with the greatest needs?
- 48 states have some form of managed care within Medicaid, however, most are small initiatives, and NO other state has proposed to include all HCBS programs into managed care to the extent and in the way Kansas is seeking.
- Regular Medical and HCBS are Different. As opposed to acute care, HCBS Waiver programs provide community-based long term-care supports (including personal care, housing, day supports, help with activities of daily living, etc.).
- State after State has thoughtfully considered whether to include all HCBS Waivers into managed care, and Legislature after Legislature overwhelmingly rejected including all Waivers.
- HCBS Waivers must be “carved out” from managed care. Kansas should first focus on working with consumers and stakeholders on appropriate models to

integrate the Waivers with Medicaid managed care. You can integrate the handful of HCBS Waiver codes with managed care and still carve them out. However, care and time should be taken to identify if and how other components of Medicaid are included in the future.

Question: Why doesn't Kansas first do what other states have done and ensured access to community based services before changes are made? Why doesn't Kansas first focus on eliminate waiting lists and make access to services a priority of any redesign effort?

We Recommend: FIRST Reduce Waiting Lists & Ensure Access Without Waits.

- Make the Waiting List & Access a Top Priority of Reform – Other states that have instituted managed care changes have made a top priority the dramatic reduction (and even the elimination!) of HCBS waiting lists.
    - Several states have dramatically and positively impacted their waiting lists as part of Medicaid changes.
    - Arizona basically has no waiting list for their community based waiver services. The waiting list was a priority of reform.
    - In Wisconsin, among the 57 counties that have managed care, many have no DD waiting list, and the others have dramatically reduced their waiting lists. *Note: managed care has been phased in over 10+ yrs in Wisconsin and 15 counties still aren't part of managed care.*
- The RFP seems to have the State of Kansas manage the waiting list independent of the managed care contracts. If this is the case, where is the focus to reduce/eliminate the waiting list? Where are the goals in the RFP or the managed care contract to require meaningful and measurable progress to dramatically reduce waiting lists?
- Using one Waiver as an example, of the four states that implemented some form of managed care within their Developmental Disability (DD) Waiver: 1) NONE have done it to the scope or extent that Kansas is proposing, 2) NONE used out-of-state, for-profit corporations as the managed care organization, 3) Three of those four states have also made community-based services an entitlement, ensuring access of services. This is an example of why access and waiting lists must be focused on first before Waivers are forced into managed care.
- Other states have made elimination of the waiting list & access to services a top priority with any Medicaid redesign – Kansas must too!
- Instead of "going all in" on managed care, Kansas should first:

- Ensure compliance with the current state law governing self direction and consumer control of HCBS (on the books since 1989!). Let's first ensure budget & decision making authority for people to hire, pay and provide benefits to their own personal care workers pursuant to state law.
- Apply for a Community First Choice Option, which would ensure community based personal care services are provided without waits while Kansas gets a permanent 6% increase in enhanced federal FMAP under Medicaid.
- Eliminate the client obligation in regards to protected income. This follows the Administration's goal of ensuring Kansans can keep more of their money. Kansas should commit to stop 'taxing' peoples social security checks because they need help to stay at home in the community. The so called "protected income level" is nothing but a huge hidden tax on our poorest citizens living on fixed incomes!

- If managed care produces savings, the waiting lists on the HCBS Waivers should be at the top of the list of where those savings are dedicated!
- <u>Kansas must first create reforms to ensure community based services are available without waiting lists.</u>

Question: With such huge changes planned, why doesn't Kansas provide independent support to help Medicaid recipients navigate and resolve the conflicts that will surely arise?

We Recommend: Support for Independent Conflict Resolution.

- Kansans who receive Medicaid benefits ("members") need support and independent professional support on the back end to navigate the new systems and ensure effective access to needed Medicaid services and supports, especially in resolving conflicts and service denials.
- Medicaid members are rightfully concerned about everything that can go wrong with the complicated formal and informal conflict resolution and other processes that can prevent their access to services & supports under a new for-profit system. This is particularly a concern because they will likely have a for-profit corporation with a profit motive standing between them and the Medicaid services/supports they need to survive.
- Support for conflict resolution that is independent of the managed care companies and the state needs to be provided to members to ensure this new system doesn't create new burdensome red tape and that the procedures can be navigated in a way that doesn't create new barriers to services.

- Kansas must create and fund professional, independent support to ensure that conflicts are resolved effectively and appropriately. This could be funded through a withhold charge on the per member rate provided to managed care corporations.

Question: What's the rush? Why is Kansas proposing that ALL of Medicaid be placed within managed care so quickly (in less than one year)? Have any other states successfully rushed such a huge change to go "all in" so quickly?

We Recommend: Managed Care should be Phased-In Cautiously.

- NO other state has successfully contracted out all of Medicaid into managed care with such break-neck speed. We believe the speed and scope of the Kansas proposal are both dangerously fast and dangerously large.
- Other states have phased in managed care over a series of years, starting locally or regionally at first, and being extremely cautious and selective with the services included (or "carved in") to managed care.
- Wisconsin started with a managed care pilot project of 5 Counties over 10 years ago, expanded it to 57 Counties, and to date still has not expanded managed care statewide (15 Counties are still not in managed care).
- What's the rush? We believe Kansas should take its time in rolling out managed care. It should be phased-in. Pilot projects should be first established and monitored. Start with regular Medical with Waivers carved out. We must learn from our successes and failures of those pilot projects first and use that to plot the next phase of managed care.

Question: Will managed care improve health outcomes? Will it save money?

We Recommend: The State Should Study this Issue more Closely to Understand the True Outcomes and Costs under Managed Care.

- Findings from two reports from the non-partisan National Bureau of Economic Research (NBER), suggest that the model of managed care proposed in Kansas will not inherently improve outcomes and will not decrease Medicaid spending.
    - "The empirical results demonstrate that the resulting switch from fee-for-service to managed care was associated with a **substantial increase in government spending but no observable improvement in health outcomes**, thus apparently reducing the efficiency of this large government program." – National Bureau of Economic Research 2002 Report (Mark

Duggan and Tamara Hayford, "Does Contracting Out Increase the Efficiency of Government Programs? Evidence from Medicaid HMOs.")

- "Our baseline estimates suggest that the average effect on Medicaid spending of shifting recipients from FFS (fee for service) to managed care is **close to zero**. This result holds for both HMO contracting and other types of MMC (Medicaid Managed Care), and suggests that the policy-induced shift of millions of Medicaid recipients from FFS to managed care during our study period did little to reduce the strain on the typical state's budget." – National Bureau of Economic Research 2011 Report (Mark Duggan and Tamara Hayford, "Has the Shift to Managed Care Reduced Medicaid Expenditures?")

- Many Kansas advocacy groups fear that shifting all of Medicaid to managed care will not improve health outcomes, but instead will increase administrative costs, resulting in cuts to the already low rates paid to providers, and increase arbitrary denials of health-promoting, necessary and life-sustaining services and supports.

Question: How will managed care ensure that people with disabilities have access to health care services when Kansas already has a high number of medically underserved areas in both rural and urban areas?

We Recommend: Carefully study the issue of sufficient provider numbers, especially in rural areas. This is yet another reason carve-out the Waivers from managed care, as people with disabilities comprise a medically underserved population in their own right.

- According to the Kansas Department of Health and Environment (KDHE) Bureau of Local and Rural Health (2011), 51 of the 105 counties in Kansas are governor-designated "medically underserved" areas based on provider-to-population ratio.
- KDHE also reports that Kansas has these health professional shortage areas:
  - By population: 59 for primary care and 60 for dental.
  - By geography: 24 for primary care, 28 for dental care, and 99 for mental health.
  - For more information: http://www.kdheks.gov/olrh/download/PCUARpt.pdf
- Research has shown that people with disabilities experience health and health care access disparities when compared to people without disabilities.
  - These disparities result from wide-ranging social, environmental and behavioral health determinants.

This document if produced by the Big Tent Coalition, a cross-age, cross-disability advocacy coalition with dozens of member organizations.

The Big Tent Coalition is asking these questions to engage in the dialogue and help ensure Legislators understand the complex nature of the Medicaid managed care proposal.

For more information, contact the Big Tent Coalition (www.bigtentcoalition.org), or the Big Tent Coalition's Convener, Rocky Nichols, at 785-273-9661.

Adopted January 19, 2012